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INSTRUCTIONS FOR COMPLETING THE MEDICARE ADVANTAGE BID PRICING TOOL

AND

THE MEDICAL SAVINGS ACCOUNT BID PRICING TOOL

FOR CONTRACT YEAR 2013

September 14, 2011

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I. INTRODUCTION

BACKGROUND

Medicare Advantage (MA) organizations must submit a separate bid to the Centers for Medicare & Medicaid Services (CMS) for each plan that they intend to offer under the Medicare Advantage program, including MA plans and Medical Savings Account (MSA) plans. For plans with service area segments, a separate bid must be submitted for each segment.

Organizations must submit the information via the CMS Health Plan Management System (HPMS) in the CMS-approved electronic format—the MA Bid Pricing Tool (BPT) or the MSA BPT. The MA BPT is not to be completed for Section 1876 Cost plans, Section 1833 Cost plans, or Programs of All-Inclusive Care for the Elderly (PACE) plans. An actuarial certification and supporting documentation must be submitted for each bid as described in Appendix A and Appendix B, respectively.

The submitted bids will be subject to review and negotiation by CMS or by any person or organization that CMS designates. As part of the review/negotiation process, CMS or its representative may request additional documentation supporting the information contained in the BPT. Organizations must be prepared to provide this information in a timely manner.

If the MA plan includes prescription drug benefits under the Medicare Part D program (that is, an MA-PD plan), then an additional Part D BPT must also be completed and submitted to CMS. Prescription drug benefits under the Medicare Part D program are not allowed to be offered with an MSA plan.

DOCUMENT OVERVIEW

This document contains general pricing considerations and detailed instructions for completing the BPT. Following are the contents of each section:

- Section I, "Introduction": contains background information and a list of key changes from CY2012, and provides sources of additional information regarding the bidding process.
- Section II, "Pricing Considerations": includes guidance for the overall approach to pricing in the BPT and topic-specific issues for bidders to consider. The section topics are arranged alphabetically.
- Section III, "Data Entry and Formulas": contains line-by-line instructions on each data entry field and describes the formulas for calculated cells.
- Section IV, Appendices A through H: contain information on Actuarial Certification, Supporting Documentation, Part B-Only Enrollees, MA Products Available to Groups, Rebate Reallocation and Premium Rounding, Suggested Mapping of MA Plan Benefit Package (PBP) Categories to BPT Categories, DE#, and the MSA BPT.

NEW FOR CONTRACT YEAR 2013 (CY2013)

Some of the key features that are new or changed for the CY2013 BPTs are listed below. The changes improve the usability and functionality of the BPT and reflect current guidance.

BIDDING RESOURCES

In addition to these instructions, the following resources provide information on CY2013 bidding:

- The CY2013 Advance Notice and draft CY2013 Call Letter may be found at http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2013.pdf.
- The CY2013 Rate Announcement and CY2013 Call Letter may be found at http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2013.pdf
- The CY2013 Actuarial Bid Training is offered as a web-based conference. The conference materials, including slides and streaming video downloads, are available at: http://www.cms.gov/MedicareAdvtgSpecRateStats/09b_BidTraining2013.asp and http://www.cms.gov/MedicareAdvtgSpecRateStats/09a_BidTrainingIntro.asp.
- For questions about the bid form, e-mail the CMS Office of the Actuary (OACT) at actuarial-bids@cms.hhs.gov.
- OACT will host weekly technical user group calls regarding actuarial aspects of the CY2013 bidding process. The conference calls will include live Question and Answer sessions with CMS actuaries. The call-in information is as follows:
  - Every Thursday
  - 11:00am – 12:30pm ET
- For technical questions about the BPT, HPMS, or the upload process, refer to the following resources:
  - The Technical BPT Instructions are located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2013 > Documentation > BPT Technical Instructions
  - The *Bid Submission User's Manual*, also available in HPMS
  - HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov
- For information about benefits and service categories, see Chapter 4 of the *Medicare Managed Care Manual* at http://www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326&intNumPerPage=10

II. PRICING CONSIDERATIONS

BIDDING/PRICING APPROACH

By statute, the bid must represent the revenue requirement of the expected population. Therefore, in most circumstances, Plan sponsors must use credible bid-specific experience in the development of projected allowed costs. This approach does not preclude Plan sponsors from reaching specific benefit and premium goals; the gain/loss margin guidance allows sufficient flexibility to achieve pricing targets provided that the overall margin meets the requirements in the guidance and that anti-competitive practices are not used.

It is important to note the distinction between reporting base period experience data in Worksheet 1 and projecting credible data for pricing. Base period experience must be reported at the bid level if the plan existed in CY2011, regardless of the level of enrollment. This experience must also be projected in Worksheet 2 and assigned an appropriate level of credibility by the certifying actuary. Data may be aggregated for determining manual rates to blend with partially credible projected experience rates or to account for significant changes in enrollment from the base period to the contract year.

SPECIFIC TOPICS

Topic

- Affordable Care Act and Quality Bonus Payment Demonstration
- Bad Debt
- Base Period Experience
- Benefits and Service Categories
- Coordination of Benefits (COB)/ Subrogation
- Cost Sharing
- Credibility
- Disease Management
- Dual-Eligible Beneficiaries
- Employer-only or union-only group Waiver plans (EGWPs)
- End-Stage Renal Disease (ESRD)
- Enrollment
- Gain/Loss Margin
- Hospice Enrollees
- Inpatient Hospital Non-Covered Days
- Manual Rating
- Medicare Secondary Payor (MSP) Adjustment
- Non-Benefit Expenses
- Non-Covered Limited Benefits
- Part B Premium and Buydown
- Plan Premiums, Rebate Reallocation, and Premium Rounding
- Plan Intention for Target Part D Basic Premium
- Point-of-Service (POS)
- Preventive Services Incentives
- Rebate Allocations
- Regional Preferred Provider Organizations (RPPO)
- Related Party (Medical and Non-Benefit)
- Risk Score Development for CY2013
- Risk Score Definitions and Information Sources
- Risk Score Calculation Approaches
- Service Area Changes
- Skilled Nursing Facility
- Supporting Documentation

Affordable Care Act and Quality Bonus Payment Demonstration

The Affordable Care Act of 2010 introduced quality bonus payments (QBPs) to MA organizations based on a five-star quality rating system. The Affordable Care Act also changed the share of savings that MA organizations must provide to enrollees as the beneficiary rebate, mandating that the level of rebate is tied to the level of the plan's QBP star rating. The law mandates two exceptions for determining the level of rebate for CY2013: (1) a low-enrollment contract and (2) a new contract under a new parent organization (PO).

The contract-level star ratings for the CY2013 QBP can be found at the following path in HPMS: HPMS Home > Quality and Performance > Part C Performance Metrics > Quality Bonus Payment Rating.

Low-Enrollment Contract

A low-enrollment contract is a contract that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because it lacked a sufficient number of enrollees to reliably measure the performance of the health plan. For 2013, a "low" enrollment contract received three stars for QBP purposes.

New Contract under New Parent Organization

A new MA contract offered by a parent organization that has not had any MA contract(s) with CMS in the previous three years is treated as a qualifying contract, per statute, until the contract has enough data to calculate a star rating. For 2013, a "new contract under new parent org" received three stars for QBP purposes.

New Contract under Existing Parent Organization

For a parent organization that has had MA contract(s) with CMS in the previous three years, any new MA contract under that parent organization received an average of the star ratings earned by the parent organization's existing MA contracts (weighted by enrollment).

CMS has announced a demonstration based on scaled bonuses; the higher a contract's star rating, the greater the QBP percentage. The following table outlines the QBP percentage, rebate factor, and rebate percentage for various star ratings in CY2013.

Star rating	CY2013 QBP %	CY2013 rebate factor	CY2013 Rebate % = ⅔ pre-ACA level (75%) + ⅓ post-ACA level (rebate factor)
5.0	5.0%	70%	73⅓%
4.5	4.0%	70%	73⅓%
4.0	4.0%	65%	71⅔%
3.5	3.5%	65%	71⅔%
3.0	3.0%	50%, except for: 70% low-enrollment contract 65% new contract under new PO 65% Employer/Union Direct Contract PFFS (ED PFFS) contract	66⅔%, except for: 73⅓% low-enrollment contract 71⅔% new contract under new PO 71⅔% ED PFFS contract
< 3.0	0.0%	50%	66⅔%

The CY2013 Advance Notice and Rate Announcement contain additional information regarding the ACA provisions and the Quality Bonus Payment demonstration.

Bad Debt

For private fee-for-service (PFFS) plans that match Medicare fee-for-service (FFS) payment rates, bad debt for uncollected enrollee cost sharing for inpatient hospital and skilled nursing facility care is to be included in medical costs. Other plans types are prohibited from directly paying for member cost sharing, but they may adjust fee schedules to account for any cost sharing that is projected to be uncollected.

Base Period Experience

The base experience must be based on claims incurred in calendar year 2011 with at least 30 days of paid claim run-out; 2-3 months of paid claim run-out is preferable.

Worksheet 1 must be completed with data at the bid level, that is, with a contract number, Plan ID, and segment combination for each bid. Note that these data must—

- Be submitted in Worksheet 1 at the bid level for all plans with experience data in 2011, regardless of the level of enrollment.
- Be provided for plans acquired by the Plan sponsor.
- Reconcile in an auditable manner to financial data.
- Be reported without adjustment in Section III. Adjustments may be made in Section IV to accommodate population, benefit design, or other changes between the base period and the projection period.
- Not be used to aggregate data from multiple plans in order to achieve credibility. Credibility is addressed on Worksheet 2.
- Include any provider incentive payments.

The medical expenses in Section III must—

- Reflect the current best estimate of incurred claims on an experience basis, including estimates of unpaid claims, but excluding margin for adverse deviation (which must be included as part of the gain/loss margin on Worksheet 4).

- Be reported on an allowable basis (before any reduction for reinsurance recoveries or cost sharing) and on a net basis.
- For Employer-only or union-only group waiver plans (EGWPs), reflect the actual cost sharing provided to groups enrolled. For other plans, reflect the full level of plan cost sharing in the plan benefit package (PBP) for all enrollees including the DE# beneficiaries. See the pricing consideration for dual-eligible beneficiaries for more information about DE# beneficiaries.
- Exclude claim experience for hospice enrollees for the time period that an enrollee is in hospice status. See the pricing consideration for hospice enrollees.
- Exclude end-stage renal disease (ESRD) claim experience for the time period that an enrollee is in ESRD status based on CMS eligibility records.
- Exclude claims experience for optional supplemental benefits.

The net medical and non-benefit expenses and CMS and premium revenue in Section VI must include all enrollees (that is, include ESRD and hospice). Section VI excludes optional supplemental benefits. Section VI is completed in total dollars (not PMPMs).

Capitated Arrangements for Medical Services

If medical services are provided under a capitated arrangement, then the utilization rates entered on Worksheet 1 must be based on claims or encounter data for the plan whether or not a related party is involved.

The requirements for the "Net PMPM" and "Allowed PMPM" entered on Worksheet 1 depend on whether or not a related party is involved.

- If a non-related party provides medical services under a capitated arrangement, the allowed cost is the capitation amount for medical services plus any related cost sharing.
- If a related party provides medical services under a capitated agreement, the allowed cost and net medical cost may need to be adjusted.
    - If the capitation paid to a related party is greater (or less) than the average cost that the related party would charge a non-related party for such services, only the average cost is included in the allowed cost. The excess (or deficiency) is considered gain/loss margin.
    - If the related party does not have credible data on which to base the average cost, such as data for a similar arrangement with a non-related party, FFS data may be used to estimate this amount.

Plan Consolidations and Enrollment Shifts

The requirements for reporting base period data for plan consolidations and enrollment shifts are described below.

✓ **Rule 1 – Plan Consolidations (i.e., Consolidated Renewals)**

When two or more plans are consolidated and the members are cross-walked into an existing or new plan, the two or more plans' base period experience must be reported on Worksheet 1 of the plan into which the members are

cross-walked. CMS allows data for more than one plan to be aggregated only in this circumstance. Note the following:

- The term "cross-walked" refers to the formal cross-walk process in HPMS whereby members are moved from one plan to another. Without an HPMS cross-walk in place, members are dis-enrolled from the terminating plan and must actively select a new plan of their choosing.
- Plans can be cross-walked each contract year. For BPT reporting purposes, the actuary must consider the cross-walks from the base period to the contract period (that is, two years of crosswalks, from CY2011 to CY2012, and then from CY2012 to CY2013).
- This rule applies when members are cross-walked within the same contract and when members are cross-walked between contracts.

✓ **Rule 2 – Shifts in Enrollment**

When enrollment shifts among plans and the base period plan is offered in the contract period, then the base period experience must be reported only in Worksheet 1 of the base period plan.

✓ **Rule 3 – Partial Experience**

Base period experience must be reported in total at the bid level for every contract-plan ID-segment ID; do not include partial plan experience on Worksheet 1.

Example 1:

An MA organization offers plans 001-00 and 002-00 in CY2011 and plans 002-00 and 003-00 in CY2013. Plan 001-00 is consolidated and the membership is cross-walked into plan 003-00 for CY2013. Base period experience must be reported on Worksheet 1 of the CY2013 BPT as follows:

- For plan 002-00 BPT, report aggregate base period experience for plan 002-00 (Rule 1 and Rule 3).
- For plan 003-00 BPT, report base period experience for plan 001-00 (Rule 1 and Rule 3).

Example 2:

An MA organization offers plans 001-00 and 002-00 in CY2011 and plans 002-00 and 003-00 in CY2013. Plan 001-00 is consolidated and the membership is cross-walked to plan 003-00 for CY2013. The certifying actuary expects most of the current membership in plan 002-00 to enroll in plan 003-00 for CY2013; however, plan 002-00 is still offered. Base period experience must be reported on Worksheet 1 of the CY2013 BPT as follows:

- For plan 002-00 BPT, report base period experience for plan 002-00 (Rule 2 and Rule 3).
- For plan 003-00 BPT, report base period experience for plan 001-00 (Rule 1).

Example 3:

An MA organization offers plans 001-00, 002-00, and 003-00 in CY2011 and plans 002-00 and 003-00 in CY2013. Plan 001-00 is consolidated and the membership is cross-walked to plan 002-00 for CY2012. Base period experience must be reported on Worksheet 1 of the CY2013 BPT as follows:

- For plan 002-00 BPT, report base period experience for plans 001-00 and 002-00 (Rule 1 and Rule 3).
- For plan 003-00 BPT, report base period experience for plan 003-00.

Example 4:

An MA organization offers plans 001-00, 002-00, and 003-00 in CY2011 and plan 003-00 in CY2013. Plan 001-00 is consolidated and the membership is cross-walked to plan 002-00 for CY2012. Plan 002-00 is consolidated and the membership is cross-walked to plan 003-00 for CY2013. Base period experience must be reported on Worksheet 1 of the CY2013 BPT as follows:

- For plan 003-00 BPT, report base period experience for plans 001-00, 002-00, and 003-00.

Benefits and Service Categories

Input items related to medical expenses must generally be entered separately for each service category displayed in the BPT.

Following are the three types of service categories:

- Services that can be only Medicare-covered.
- Services that can be only non-covered (for example, transportation benefits in line 1, "Transportation (Non-Covered)").
- Medicare-covered services that may be supplemented, as an A/B mandatory supplemental benefit (for example, the cost for additional days not covered by Medicare in line a, "Inpatient Facility").

For the third type, values are allocated between Medicare-covered benefits and A/B mandatory supplemental benefits in Worksheet 4 as specified by the user. This allocation must be consistent with the benefit type classification in the PBP.

See Appendix F for a suggested mapping of BPT and PBP service categories. For more information on benefits and service categories, see Chapter 4 of the *Medicare Managed Care Manual*, "Benefits and Beneficiary Protections," at http://www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326

Coordination of Benefits (COB)/Subrogation

The COB/Subrogation service category is intended to include only those amounts that are to be settled outside the claim system. If an MA organization pays claims for its estimated liability only (that is, net of the amount that is the responsibility of another payer, such as an employer plan or auto policy), the MA organization's net liability amount (before cost-sharing reductions) may be entered on Worksheet 1, Section III, lines a through q.

Cost Sharing

The cost-sharing information entered in the BPT must tie to data in the PBP and, as such, must contain enough descriptive information to be easily cross-checked by CMS. Note that, although there are not individual entries for each cost-sharing item listed in the PBP, the value of all cost-sharing items must be reflected in the total per member per month (PMPM) amount in Worksheet 3. Further, the description entered in each line of Worksheet 3 must identify all plan cost sharing associated with the PMPM amount on that line.

The cost-sharing descriptions in Worksheet 3 are to be used by plan managers, marketing staff, and plan actuaries to ensure that the benefits priced in the BPT are consistent with those in the PBP, as part of the quality control process for bid submissions. CMS recommends that the actuary include the PBP service categories (description of the cost-sharing amounts and the corresponding PBP line numbers) that are priced in each row of Worksheet 3. However, any PBP line numbers are to be shown in addition to, and not in lieu of, a description of the cost-sharing amounts.

For plan cost sharing designed to match Medicare fee-for-service cost sharing (an approach used by some employer-only or union-only group waiver Plan sponsors), the user must enter "Medicare FFS cost sharing" (or similar wording) in the cost-sharing description for each applicable category. This wording is needed because the final cost-sharing dollar amounts will not be known when the bid is initially submitted. Note that this approach applies for the BPT but not the PBP.

The actuary may also use the actuarial equivalent cost-sharing factors shown in Worksheet 4 to estimate the PMPM amount for plan cost sharing that is designed to match Medicare FFS cost sharing. In this case, the user may enter the entire value of cost sharing in columns i and j and adjust the projected allowed costs in order to reflect this PMPM value of the cost-sharing amount. This approach does not apply for other levels of cost sharing.

We expect that the cost sharing for travel benefits (obtained outside the plan's service area) will be entered as out-of-network (OON) cost sharing in Worksheet 3 (columns m and n). Further, if the plan applies different cost sharing for travel benefits than for "local" benefits (obtained within the service area), then this difference must be specified in the OON cost-sharing description in column m. However, if the travel benefit is provided in-network—that is, within the network established by the MA organization or its affiliate for other health plans in other service areas—then the Plan sponsor may enter the cost sharing for the travel benefit as in-network (Worksheet 3, columns e through j). As is the case with OON cost sharing, if the plan applies different cost sharing for travel benefits than for "local" benefits (obtained within the service area), then this difference must be specified in the in-network cost-sharing description in column h.

Any member premium(s) and Part D cost sharing must be excluded from Worksheet 3.

Credibility

Based on an application of classical credibility theory to Medicare FFS experience, CMS has established a guideline for full credibility for MA plans of 24,000 total base period member months. The formula for partial credibility is the square root of the result of base period member months divided by 24,000. This formula is a guideline; actuaries must consider the quality of the base period experience when calculating credibility. Plan sponsors may use a

different credibility methodology only if the alternate method is consistently applied among all plans in the contract and is deemed acceptable by CMS.

The certifying actuary must adhere to the following rules of overriding the CMS credibility formula for partial credibility:

- If the CMS formula for partial credibility is applied to base period members months and the resulting credibility is—
    - Less than or equal to 20 percent (that is, 960 or fewer MA member months), then the actuary may override the computed credibility with 0 percent credibility.
    - Greater than or equal to 90 percent (that is, 19,440 or more MA member months), then the actuary may override the computed credibility with 100 percent credibility.

The override is applicable only to the CMS credibility formula; it is not applicable to any alternative credibility formula. If the certifying actuary overrides the CMS credibility, then the override option must be applied consistently among all bids and cannot be applied selectively to certain bids. If the certifying actuary proposes a variation to the override, then the alternate credibility method proposal and documentation requirements apply.

The credibility assumption for projected allowed costs may vary—

- By service category, which may be appropriate if a subset of providers is reimbursed on a capitation basis or if manual rates are being used for newly added benefits.
- By line of business within a contract—for example, special needs plans (SNPs) as compared to other plans.
- From the credibility method used in the development of risk scores, as risk scores tend to reach full credibility at lower levels of membership.
- From the credibility method used for ESRD membership—which may reach full credibility at lower levels of member months due to the high amount of claims.

Credibility factors are applied to PMPM costs in the BPT. Therefore, actuaries who use different credibility factors for utilization than for unit costs must develop blended factors to use in the bid form.

When the base period experience is partially credible and included in experience used to develop the manual rate, the actuary must consider the extent to which the manual rate development double counts the base period experience. That is, is the manual rate developed relatively independent of the base period experience? (See "The Complement of Credibility" by Joseph A. Boor, *Proceedings of the Casualty Actuarial Society, May 1996, Volume LXXXIII*.) If the proposed manual rate lacks sufficient independence from the base period experience, then an alternative manual rate must be developed (by removing the base period experience from the manual rate development and/or by increasing the use of other, non-base period experience in the manual rate development). As an equivalent alternative to removing the base period experience from the manual rate development, CMS will allow the credibility percentage in the BPT to be adjusted such that the experience for the plan is assigned the appropriate credibility (based on the CMS standard formula), taking into consideration the proportion of the manual experience that is from the subject base plan.

The manual rate used in a credibility-weighted projection must be based on a sufficient volume of data and be an appropriate predictor of the plan's projected experience.

When assessing the credibility of plan experience, actuaries must consider ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages* and ASOP No. 8, *Regulatory Filings for Health Plan Entities*.

Disease Management

Disease management (DM) expenses are to be treated as medical expenses, non-benefit expenses, or both, depending upon the nature of the expense. For DM services furnished in a clinical setting by approved providers, costs are to be treated as medical expenses. The cost of durable medical equipment (DME) associated with DM activities is typically classified as a medical expense.

For care management services provided under a SNP model of care—for example, services provided by an interdisciplinary care team as mandated by Medicare Improvements for Patients and Providers Act (MIPPA) and addressed in a HPMS memorandum dated September 15, 2008—costs are treated as medical expenses. Should the team provide additional services, any added costs may be classified by the certifying actuary as medical expenses or as non-benefit expenses.

Absent additional CMS guidance, other DM and care coordination costs —such as those incurred during recruitment, enrollment, and general program communications—are to be classified as non-benefit, or administrative, expenses. In all cases, the classification of DM expenses in the bid must be explained in the supporting documentation for projected allowed costs and non-benefit expenses.

Dual-Eligible Beneficiaries

Dual-eligible beneficiaries are individuals who are eligible for both Medicare and Medicaid benefits under Titles XVIII and XIX of the Social Security Act, respectively. There are several categories of dual-eligible beneficiaries, such as qualified Medicare beneficiaries (QMBs), with different benefits based on income and other qualifying circumstances. Some dual-eligible beneficiaries receive benefits in the form of reduced or eliminated Medicare cost sharing.

The BPT reflects the difference in cost-sharing liability for certain dual-eligible beneficiaries in the development of total medical costs.

Definition of DE#

In the BPT and these instructions, the term "DE#" (*d-e-pound*) refers to dual-eligible beneficiaries without full Medicare cost-sharing liability. Included are dual-eligible beneficiaries who receive benefits in the form of reduced, as well as eliminated, Medicare cost sharing. The non-DE# population includes dual-eligible beneficiaries with full Medicare cost-sharing liability and beneficiaries who are not eligible for Medicaid (that is, non-dual eligible).

Per federal statute, QMBs and qualified Medicare beneficiaries with full Medicaid benefits (QMB+) are not liable for Medicare cost sharing; therefore, these individuals are always considered to be DE# beneficiaries. The certifying actuary must determine

which additional beneficiaries are DE# based on the Medicaid cost-sharing policy for the states or territories in the plan's service area.

The certifying actuary may use plan-specific enrollment data available in HPMS, under the "Risk Adjustment" link, to determine the DE# population as follows:

- Consider the 2011 membership data posted in HPMS for the contract plan-ID segment(s) listed in Worksheet 1 for the base period.
- Consider the membership in the QMB and QMB+ categories to represent the entire DE# population only if the percentage of total dual-eligible beneficiaries (who comprise all dual-eligible categories and not just the QMB and QMB+ categories) is less than 10 percent of total beneficiaries.
- If the percentage of total dual-eligible beneficiaries is greater than or equal to 10 percent of total beneficiaries, then determine which dual-eligible beneficiaries, in addition to QMB and QMB+ beneficiaries, are DE# based on the Medicaid cost-sharing policy for the states or territories in the plan's service area.

To learn more about the enrollment data posted in HPMS, see the pricing consideration for risk score definitions and information sources.

The BPT must reflect data and costs for the DE# and non-DE# populations separately, as explained in this section and summarized in Appendix G.

✓ **Worksheet 1 – Base Period Data**

The user must enter distinct base period member months and risk scores separately for the total and non-DE# populations regardless of the size of the actual and projected DE# populations. The BPT calculates base period member months and risk scores for the DE# population based on the user-entered values for the total and non-DE# populations. All other data on Worksheet 1 are to be entered for the total population.

✓ **Worksheet 2 – Projected Allowed Costs (Blended Rates)**

The BPT calculates blended allowed costs for the total population (column o) based on the projected experience rate and manual rate. The CMS credibility guideline applies to total (DE# plus non-DE#) member months.

The user must enter projected allowed costs for both the non-DE# and DE# populations (columns p and q) as follows:

- Enter projected allowed costs for the non-DE# beneficiaries in column p and projected allowed costs for the DE# beneficiaries in column q.
- If DE# projected member months are between 10 percent and 90 percent inclusive of the total projected member months, then enter distinct DE# and non-DE# projected allowed costs (columns p and q).
- If DE# projected member months are less than 10 percent or greater than 90 percent of the total projected member months, then the user may, at the discretion of the certifying actuary, enter—
  - Non-DE# projected allowed costs (column p) equal to the projected allowed costs for the total population (column o); and

- DE# projected allowed costs (column q) equal to the projected allowed costs for the total population (column o).

- If the projected member months for the DE# population or for the non-DE# population are equal to zero, then enter projected allowed costs for the non-DE# beneficiaries (column p) and for the DE# beneficiaries (column q) equal to the projected allowed costs for the total population (column o). Do not enter zero for these costs.
- Complete Worksheet 2, column p on a "per non-DE# member per month" basis, and complete column q on a "per DE# member per month" basis.

✓ **Worksheet 3 – Cost Sharing**

The user must enter cost-sharing information in Worksheet 3 based on benefits outlined in the PBP, including the case when the number of projected non-DE# member months equals zero.

The values apply to the total population or to the non-DE# population as follows:

- If (i) DE# projected member months are less than 10 percent, or greater than 90 percent, but not equal to 100 percent of total projected member months, and (ii) the projected allowed costs in Worksheet 2 for the total, DE#, and non-DE# populations are all equal, then the utilization rates entered in Worksheet 3, and hence the PMPM value of cost sharing, may, at the discretion of the certifying actuary, apply to either—
  - The non-DE# population; or
  - The total population.
- If DE# projected member months are 100 percent of total projected member months, then the utilization rates entered in Worksheet 3, and hence the PMPM value of cost sharing, must apply to the total population.
- In all other cases, the utilization rates and PMPM value of cost sharing apply to the non-DE# population.

✓ **Worksheet 4 – Projected Required Revenue**

Total medical expenses are calculated separately for non-DE#s, DE#s, and all beneficiaries in subsections A, B, and C, respectively.

- In subsection A (non-DE#s), net medical expenses for Medicare-covered benefits (column o) are calculated based on FFS actuarially equivalent cost-sharing proportions (column k).
- In subsection B (DE#s), comparable medical expenses are calculated for DE# beneficiaries, taking into account the reduced or eliminated cost-sharing liability of dual-eligible beneficiaries, including the state or territory Medicaid cost sharing (column k). Specifically, the Medicare-covered net PMPM reflects—
  - What the plan pays the provider for Medicare-covered services; plus
  - The actual cost sharing for Medicare-covered services; less
  - The state or territory Medicaid cost sharing for Medicare-covered services.

- In subsection C (all beneficiaries), the BPT weights the non-DE# and DE# costs by their respective projected member months (from Worksheet 5) to calculate costs for all beneficiaries. The user must enter total non-benefit expenses and the gain/loss margin for all beneficiaries.

Considerations for developing data for DE# beneficiaries in subsection B include the following:

- All values must be calculated on a "per DE# member per month" basis.
- In column f, plan cost sharing reflects the cost sharing that would be paid if the beneficiary actually paid the plan cost sharing in the PBP.
  - This amount is calculated automatically based on DE# allowed costs in Worksheet 2 and the ratio of non-DE# plan cost sharing and allowed costs in subsection A.
  - However, the default formulas may be overwritten at the discretion of the certifying actuary.
- In column k, the "Medicaid Cost Sharing" reflects the cost sharing that the beneficiary is liable to pay.
  - The "Medicaid Cost Sharing" includes the following:
    - Cost-sharing amounts required by state or territory Medicaid programs based on the eligibility rules for subsidized cost sharing for DE# beneficiaries in the plan's service area.
    - Plan cost sharing for non-covered, non-Medicaid benefits.
  - The user must—
    - Calculate the "Medicaid Cost Sharing" as a weighted average of the PMPM cost sharing for all DE# members.
    - Enter data in all cases. The cells must not be left blank.
  - If (i) DE# projected member months are less than 10 percent of total projected member months, and (ii) the projected allowed costs in Worksheet 2 for the total, DE#, and non-DE# populations are all equal, then the user may, at the discretion of the certifying actuary, enter—
    - A zero amount; or
    - The state or territory Medicaid required level of beneficiary cost sharing, if any.

In Section V, if the Plan sponsor has a separate contract with a state or territory for Medicaid services, then enter projected Medicaid revenue and cost for members of the MA plan.

- The projected Medicaid cost—
  - Includes those benefits, not reflected elsewhere in the bid, that the Plan sponsor has contracted to provide under the state or territory Medicaid program.
  - Reflects the full cost, which includes benefit expenses and non-benefit expenses.

- May include prescription drug benefits that the Commonwealth of Puerto Rico requires to be offered in order to participate in the Platino Program beyond what is submitted in the Part D bid.

- The projected Medicaid revenue is the corresponding revenue not reflected elsewhere in the bid.
- The values must be on a "per-DE#-member-per-month" basis.

✓ **Worksheet 5 – Benchmark**

The user must enter—

- County-specific projected member months and projected risk factors for the total population in Section VI (columns e and f).
- Distinct projected member months and projected risk factor for the non-DE# population in Section II (lines 1 and 4).

In Section II, the BPT displays the total member months and average risk factor for the total population based on the county-level information. Values for the DE# population are calculated automatically from the values for the total and the non-DE# populations.

Considerations for developing projected member months include the following:

- The user must not round projected non-DE# member months to 0 percent or 100 percent, even if non-DE# projected member months are less than 10 percent, or greater than 90 percent, of total projected member months.
- CMS expects non-zero DE# projected member months when there are DE# members in the base period. The DE# projected member months may be zero (that is, the user may enter non-DE# projected member months equal to the member months for the total population) only if—
  - All of the existing DE# members terminated and the probability of enrolling DE# members is zero;
  - The certifying actuary adequately explains why the DE# projected membership is zero; and
  - The user enters non-DE# projected member months and risk score equal to the corresponding values for the total population.

Non-DE# and DE# projected risk scores are determined as follows:

- If the projected allowed costs in Worksheet 2 for the total, DE#, and non-DE# populations are not all equal, the user must enter a distinct non-DE# projected risk factor.
- If the projected allowed costs in Worksheet 2 for the total, DE#, and non-DE# populations are all equal, the user must enter a projected risk factor for the non-DE# population equal to the projected risk factor for the total population.

Employer-Only or Union-Only Group Waiver Plans (EGWPs)

Each employer-only group bid must reflect the composite characteristics of the individuals expected to enroll in the plan for the contract year and the expected underwriting assumptions

for all groups, in aggregate. In addition, projected enrollment within the plan's service area must be consistent with the location of employer groups.

Note that the user must enter a county code in Worksheet 5 for each county in the plan's service area in order to generate a county-level payment rate, although the projected member months (and risk factor) can be zero.

See Appendix D, "MA Products Available to Groups", for more information.

End-Stage Renal Disease (ESRD)

All information provided on Worksheets 1 through 7 must exclude the experience for enrollees in ESRD status, for the time period that enrollees are in that status based on CMS eligibility records, with the exception of Worksheet 1 Section VI and Worksheet 4. Note that all Plan sponsors must enter the projected CY ESRD member months in the "ESRD Subsidy" section of Worksheet 4. Do not leave this field blank.

ESRD Subsidy

The benchmarks calculated in the MA bid form exclude enrollees in ESRD status, as does the projection of plan expenditures. However, all individuals enrolled in the plan, including those in ESRD status, are required to pay the same plan premium and are offered the same benefit package. In order to account for the projected marginal costs (or savings) of plan enrollees in ESRD status, the BPT allows for an adjustment that is allocated across all plan members (ESRD and non-ESRD enrollees). The adjustment is split into two sections, basic benefits and supplemental benefits, although the entire subsidy is added to A/B mandatory supplemental benefits.

✓ **Basic Benefits**

The inputs in the Medicare-covered section are (i) projected CMS capitation revenue, (ii) projected net medical expenses, and (iii) projected non-benefit expenses. The projected margin requirement is calculated based on the values for the non-ESRD bid. All fields in this section are to reflect Medicare levels of cost sharing (for example, 20 percent cost sharing for Part B services once the deductible has been met) and must be reported on a "per ESRD member per month" basis.

If the organization does not have fully credible ESRD experience, it may blend the experience with manual rates similar to what is done on Worksheet 2 for non-ESRD enrollees.

The BPT will automatically calculate the plan's costs for basic benefits of ESRD enrollees and will allocate these costs across all plan members (ESRD and non-ESRD enrollees).

✓ **Supplemental Benefits**

The inputs in this section are (i) the projected cost-sharing reduction PMPM for ESRD enrollees, and (ii) the projected PMPM cost of additional benefits for ESRD enrollees. Entries must be reported on a "per ESRD member per month" basis.

The BPT will calculate the incremental cost of supplemental benefits for ESRD enrollees and will allocate these costs across all plan members (ESRD and non-ESRD).

If a zero incremental cost of Mandatory Supplemental (MS) is intended, then the user may either—

- Leave the MS input fields blank; or
- Set these costs equal to the projected cost-sharing reduction PMPM and cost of additional benefits PMPM for non-ESRD enrollees.

Enrollment

The projected enrollment for the MA bid must be consistent with that for the corresponding Part D bid and must reflect the same underlying population. Acceptable differences in projected member months entered in the Part D bids include out-of-area members, ESRD members, and possibly hospice members, as outlined in these instructions.

If the projected enrollment in a particular county in the plan's service area is zero, the user must enter the county code with zero projected member months in order to generate a county-level payment rate for that county.

Gain/Loss Margin

Gain/loss margin refers to the additional revenue requirements beyond medical expenses and non-benefit expenses. It is allocated to Medicare-covered services and A/B mandatory supplemental benefits based on the distribution of total medical expenses across these categories (excluding the impact of the ESRD subsidy).

Gain/loss margin requirements apply at the PBP level and at the plan-type grouping level. (Plan types consist of general enrollment plans and institutional/chronic care special needs plans, dual-eligible special needs plans, EGWPs, and Part D plans.) At the plan-type grouping level, the overall gain/loss margin for general enrollment plans and institutional/chronic care special needs plans (I/C SNPs) combined must be consistent with the Plan sponsor's corporate requirement. Further, the overall gain/loss margin for each plan grouping must be consistent with the gain/loss margin for general enrollment plans and I/C SNPs combined. (If corresponding general enrollment plans are not offered, the guidance for general enrollment plans and I/C SNPs applies directly to the overall gain/loss margin for the plan grouping.)

PBP-Level Guidance

There is flexibility in setting the gain/loss margin at the PBP level provided that the overall margin meets CMS requirements, anti-competitive practices are not used, the PBP offers benefit value in relation to the margin level, and a negative margin satisfies the guidance in this subsection.

If the projected gain/loss level in the BPT is negative, the Plan sponsor must develop, submit, and follow a business plan that achieves profitability in 3 to 5 years. CMS expects that in subsequent years, projected gain/loss margins will meet or exceed the year-by-year gain/loss margins contained in the original business plan. Exceptions to the business plan requirement are cases in which MA products are paired and the

pricing reflects implicit "subsidies" across benefit or service area offerings. The plans in the product pairing must—

- Have identical service areas;
- Be of the same plan type; and
- Have a positive combined gain/loss margin.

Examples include a low-benefit plan with a positive margin paired with a rich-benefit plan with a negative margin, or an MA-only plan paired with an MA-PD plan with the same MA benefits.

Anti-competitive practices will not be accepted. For example, significantly low or negative margins for plans that have substantial enrollment and stable experience, or "bait and switch" approaches to specific plan margin buildup, will be rejected, absent sufficient support that such pricing is consistent with these instructions.

Plan-Type Grouping Level Guidance

Within each plan-type grouping category—

- Gain/loss margins entered on the BPT are to be consistent on a year-by-year basis. Actual organization returns are expected to vary year to year, in practice, but to achieve the organization's requirement over a longer-term period (for example, 3 to 5 years).
- The overall margin levels included in the MA and Part D components of MA-PD bids must be within a reasonable range of each other, not to exceed plus or minus 1.5 percent, with any variation reflecting the different levels of financial risk for the two components. The individual Part D margin of an MA-PD bid can either be the same for all plans or vary by plan in relation to the MA margin.

✓ General Enrollment Plans and Institutional/Chronic Care SNPs (I/C-SNPs)

The overall gain/loss margin levels for general enrollment plans and I/C SNPs combined—

- Are to be consistent with the Plan sponsor's corporate requirement.
- May be determined at the contract level, organization level, or parent organization level.
- As measured by percentage of revenue, are to be within a reasonable range, not to exceed plus or minus 1.5 percent of other lines of business.

Additionally, for sponsors that price based on return on investment (ROI) or return on equity (ROE), the projected general enrollment and I/C SNP returns must be consistent with the company's return requirements. Comparisons to other lines of business must take into account the degree of risk or surplus requirements of the business.

✓ Special Needs Plans Serving Dual-Eligible Beneficiaries (DE-SNPs)

The foundation for the claim and administrative costs for DE-SNPs must be based on appropriate experience. The gain/loss margin assumptions used for

DE-SNP plans depend upon whether or not corresponding general enrollment plans or I/C SNPs are offered.

- If corresponding general enrollment plans or I/C SNPs are offered, the margin assumptions used for general enrollment plans and I/C SNPs must be the basis for the margin requirements for DE-SNPs.
  - Organizations may choose to use the overall margin levels for general enrollment plans and I/C SNPs (which are determined at a contract level, organization level, or parent organization level, consistent with the determination of the Plan sponsor's corporate requirement) as the basis for the DE-SNP margin assumptions.
  - CMS expects the margin level for DE-SNPs to be within a small range of the margin level for general enrollment plans and I/C SNPs (that is, up to 1 percent). Exceptions for unique situations must be fully explained and supported.
- If corresponding general enrollment plans or I/C SNPs are not offered, then the margin guidance for general enrollment plans applies to the DE-SNP margin pricing.
  - Overall DE-SNP margin levels are to be consistent with the organization's margin requirement.
  - Overall DE-SNP margin levels are to be within a reasonable range of the margin for other similar lines of business, not to exceed plus or minus 1.5 percent of the margin.

✓ **Employer-Only or Union-Only Group Waiver Plans (EGWPs)**

- The foundation for the claim and administrative costs for EGWPs must be based on appropriate EGWP experience. The gain/loss margin requirements for EGWPs depend upon whether or not corresponding general enrollment plans or I/C SNPs are offered.
- If corresponding general enrollment plans or I/C SNPs are offered, the margin assumptions used for general enrollment plans and I/C SNPs must be the basis for the margin requirements for EGWPs.
  - Organizations must calculate the overall margin for EGWPs at the contract level.
  - The margin for EGWPs must be positive and within a reasonable range of the margin for general enrollment plans and I/C SNPs, not to exceed minus 5 percent or plus 1 percent of the margin.
- If corresponding general enrollment plans or I/C SNPs are not offered, then the margin guidance for general enrollment plans and I/C SNPs applies to the EGWP margin pricing.
  - Overall EGWP margin levels are to be consistent with the organization's margin requirement.
  - Overall EGWP margin levels are to be within a reasonable range of the margin for other similar lines of business, not to exceed plus or minus 1.5 percent of the margin.

Outside Funding Sources and Non-Benefit Expenses

The gain/loss margin may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.

When Medicare benefits are funded by an outside source (such as a state Medicaid program or an employer group), the gain/loss margin must be consistent for Medicare and the other funding source(s).

Hospice Enrollees

When a Medicare Advantage enrollee goes into hospice status, original Medicare assumes responsibility for Part A and Part B services, and the MA plan continues to cover supplemental benefits. Since the Plan sponsor is not liable for Medicare-covered benefits, in this situation, base period member months, base period risk scores, projected member months, and projected risk scores must exclude enrollees for the time period that they are in that status. The "Monthly membership Report" (MMR) data include hospice status.

However, since hospice enrollees continue to receive mandatory supplemental benefits from the MA plan, the projected allowed cost PMPM may reflect claim costs for these enrollees for mandatory supplemental benefits, at the discretion of the certifying actuary—for example, for a dental or another additional benefit.

Inpatient Hospital Non-Covered Days

CMS developed a 1.2-percent factor based on FFS data that can be used as a "safe harbor" for determining the proportion of inpatient days that are non-covered. If the non-covered hospital pricing is based on an assumption other than the safe harbor, support for the data and methodology used in the development of that assumption is required.

Manual Rating

Manual Rating with FFS Data

Special considerations, and corresponding documentation, are required when using Medicare FFS data as a manual rating source. Many of the available FFS data are not directly applicable and/or detailed enough to be used as the sole source for projection of medical expenses. For example, it is inappropriate to tabulate claims data using Medicare Public Use Files (PUFs) without making adjustments for corresponding demographic, health, and geographic profiles of the claimants and to account for the non-claimants. Similarly, since the FFS data published in the BPT and/or the MA rate book development files are not split by benefit type, another appropriate source must be used to allocate the data to all of the BPT service categories. Further, as is the case with use of all manual rating sources, adjustments must be made to account for claim expenses that are not reflected in the FFS data, such as claim run-out, inclusion of expenses excluded from the data, and adjustments for medical education expenses.

FFS Costs Used for the Actuarial Equivalent Cost-Sharing Factors

Please note that the FFS costs used for the actuarial equivalent cost sharing do not include home health care costs since there is no cost sharing for home health services in Medicare FFS. Experience for ESRD enrollees is excluded, as are the costs for hospice services, since MA enrollees do not receive Medicare-covered hospice services through the MA plan. However, hospice enrollees have not been excluded in calculating the PMPM FFS costs. Further details on the development of the cost-sharing factors, such as the handling of Indirect Medical Education (IME), Graduate Medical Education (GME), and other costs, may be found at www.cms.gov under Medicare > Medicare Advantage Rates & Statistics > Ratebooks & Supporting Data.

Medicare Secondary Payer (MSP) Adjustment

The Medicare Secondary Payer (MSP) adjustment is used in the BPT to reflect the reduced payments to MA plans for enrollees whose primary coverage is not Medicare (that is, enrollees with MSP status of working aged, ESRD, or disabled). Although CMS reduces payments for MSP status at the beneficiary level, the BPT applies the MSP adjustment at the bid level.

The projected MSP adjustment must be bid specific consistent with the development of projected allowed costs. Any reduction in these projected allowed costs must reflect only the additional MSP savings from the base period to the contract year.

MSP data provided by CMS serve as the basis for projecting the MSP adjustment. See the following exhibits in the Medicare Advantage and Prescription Drug Plan Communications User Guide Appendices for information on the data files sent to Plan sponsors:

- E.30 "Monthly MSP Information Data File" – This monthly file provides information on the COB data used to adjust that month's payment and is provided to allow plans to reconcile beneficiary payments.
- E.31 "Other Health Coverage Information Data File" – This monthly file lists all of the plan's enrolled beneficiaries for whom Medicare is a secondary payer, along with information on these beneficiaries' primary payer(s).

The link is http://www.cms.gov/MAPDHelpDesk/02_Plan_Communications_User_Guide.asp.

The MSP adjustment is combined with the projected risk score to produce the conversion factor that is used in the BPT as an intermediate step between the standardized and risk-adjusted bid and benchmark. The method to calculate the MSP adjustment is described below.

- MSP adjustment = 1 – X/Y, where

  X = Bid portion of payment reflecting reduced payments for MSP beneficiaries, and

  Y = Bid portion of payment that would be paid if no beneficiaries had a payer that was primary to Medicare.

- The bid portion of payment used to calculate the MSP adjustment exclude MA rebates.

  Example:

  $12,000,000 = Total MA payment for the plan (which includes all rebates except rebates for reduction of Part B premium and Part D basic premium).

$2,253,000 = The sum of rebates for cost-sharing reduction, other mandatory supplemental benefits, and Part D supplemental benefits for the plan.

X = $12,000,000 – $2,253,000 = $9,747,000

Y = $10,000,000

The MSP adjustment = 2.53% = 0.0253=1 – $9,747,000 / $10,000,000.

Non-Benefit Expenses

Non-benefit expenses are all of the administrative costs incurred in the operation of the MA plan.

Worksheet 4 distributes the non-benefit expenses proportionately between Medicare-covered benefits and A/B mandatory supplemental benefits (excluding the PMPM impact of the ESRD subsidy). Non-benefit expenses are further distributed within A/B mandatory supplemental benefits between "Additional Services" and "Reduction of A/B Cost Sharing."

The non-benefit expenses must be entered separately on the BPT for the following categories:

- Marketing & Sales
  - This category includes all direct and indirect marketing and sales expenses for the MA plan.
  - Examples include, but are not limited to the costs of—
    - Marketing materials;
    - Commissions;
    - Enrollment packages;
    - Identification cards; and
    - Salaries of sales and marketing staff.
- Direct Administration
  - This category includes all expenses for all functions that are directly related to the administration of the MA program.
  - Examples include, but are not limited to—
    - Customer service.
    - Billing and enrollment.
    - Medical management.
    - Claims administration.
    - Part C National Medicare Education Campaign (NMEC) user fees. Plan sponsors may use the CMS estimate, which amounts to $0.28 PMPM on a national basis for CY2013, or develop an alternative estimate that is consistently applied to all plans in the contract—for example, the Plan sponsor's historical amount relative to the CMS annual national estimate.
    - Uncollected enrollee premium.
    - Certain disease management functions. See the "Disease Management" pricing consideration.

- Indirect Administration
    - This category includes expenses for functions that may be considered "corporate services," such as the position of CEO, accounting operations, actuarial services, legal services, and human resources.
- Net Cost of Private Reinsurance (that is, reinsurance premium less projected reinsurance recoveries).

All non-benefit expenses must be reported using appropriate, generally accepted accounting principles (GAAP). For example, acquisition expenses and capital expenditures must be deferred and amortized according to the relevant GAAP standards (to the extent that is consistent with the organization's standard accounting practices, if not subject to GAAP). Also, acquisition expenses (marketing and sales) must be deferred and amortized in a manner consistent with the revenue stream anticipated on behalf of the newly enrolled members. Guidance on GAAP standards are promulgated by the Financial Accounting Standards Board (FASB). Of particular applicability is FASB's Statement of Financial Accounting No. 60, *Accounting and Reporting by Insurance Enterprises*.

Costs not pertaining to administrative activities must be excluded from non-benefit expenses. Such costs include goodwill amortization, income taxes, changes in statutory surplus, investment expenses, and the cost of lobbying activities. Similarly, non-insurance revenues pertaining to investments and fee-based activities cannot be reflected in the bid. See the announcement about lobbying activities released via an HPMS memorandum dated October 16, 2009.

Start-up costs that are not considered capital expenditures under GAAP are reported as follows:

- Expenditures for tangible assets (for example, a new computer system) must be capitalized and amortized according to relevant GAAP principles.
- Expenditures for non-tangible assets (for example, salaries and benefits) must be reported in a manner consistent with the organization's internal accounting practices and the reporting of similar expenditures in other lines of business.

Non-benefit expenses that are common to the MA and Part D components of MA-PD plans must be allocated proportionately between the Medicare Advantage and Part D BPTs.

When Medicare benefits are funded by an outside source (such as a state Medicaid program or an employer group), the non-benefit expenses must be allocated proportionately between Medicare and the other revenue source.

Non-Covered Limited Benefits

For non-covered limited benefits with no cost sharing, the amounts over the limit must not be included as allowed costs in the bid form.

> **Example:** The PBP contains a hearing aid benefit with a $500 annual cost limit and no cost sharing. If the average cost of a hearing aid is $2,500, the allowed PMPM must be based on the $500 maximum benefit, not on a $2,500 cost offset by a cost-sharing entry in Worksheet 3 for the $2,000 paid by the beneficiary.

Part B Premium and Buydown

MA enrollees are required to pay the Part B premium, but it may be reduced by the MA organization through the use of MA rebate dollars.

Note that the Part B premium charged by CMS is not the same for all Medicare beneficiaries.

- Section 1839 of the Social Security Act, as amended by section 811 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and section 5111 of the Deficit Reduction Act of 2005, provides for an income-related reduction in the government subsidy of the Medicare Part B premium. Under this provision, for those beneficiaries meeting specified income thresholds, a monthly adjustment amount is added to the Part B premium. The addition of monthly adjustment amounts to the Part B premium obligation of higher-income beneficiaries was phased in over 3 years, beginning in 2007.
- Certain beneficiaries' premium increase is limited by the increase in their Social Security checks (that is, the "hold harmless" provision).
- States, or another third party, may pay the Part B premium for certain beneficiaries.
- Certain beneficiaries may pay a late-enrollment penalty.

Given the MA requirement that benefits must be uniform within an MA plan, the amount of rebate dollars that can be applied to the Part B premium is limited to the amount pre-populated in the BPT by CMS at the time when the BPT is released.

The bid pricing tool and instructions are released annually in April, but the Part B premium is not announced by CMS for the upcoming contract year until several months later. Therefore, plans must use the CMS pre-populated amount in the bid form to determine the level of rebates to allocate to the Part B premium buydown.

Plan Premiums, Rebate Reallocation, and Premium Rounding

The MA BPT calculates the plan's premium for services under the Medicare Advantage program. Estimated Part D premiums, calculated in the separate Part D BPT, are then entered in the MA BPT in order to—

- Underscore the relationship of MA rebates and Part D premiums.
- Recognize the integrated relationship of the MA and Part D programs, which are viewed by the enrollee as a single product with a single premium.
- Display the total estimated plan premium (sum of MA and Part D).

When the bid is initially submitted in June, the Part D basic premium entered in the MA BPT is an estimated value. The actual premium will be calculated by CMS following CMS' publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional preferred provider organization (RPPO) benchmarks (typically in August). Therefore, for MA-PD plans, the premium shown on the MA BPT may not be the final plan premium for CY2013.

For local MA-only plans, the premium shown on the MA BPT in the initial June submission is the final actual premium (not an estimate), since these plans are not affected by the Part D national average monthly bid amount and regional PPO benchmark calculations. Local

MA-only plans do not have an opportunity to resubmit in August for rebate reallocations. The initial June bid submission must reflect the desired plan premium.

For RPPO plans, the initial bid submission in June contains an estimated MA premium. The actual MA premium will not be known until August, when the regional PPO benchmarks are calculated by CMS. Note that after the MA regional PPO benchmarks are released by CMS, all regional MA Plan sponsors are required to resubmit the MA BPTs in order to reflect the actual plan bid component in Worksheet 5, and they may need to re-allocate rebates accordingly. This requirement also applies to EGWP regional MA plans (that is, all EGWP RPPOs are required to resubmit the MA BPTs in August after the announcement of the regional MA benchmarks).

MA-PD plans and regional MA-only Plan sponsors have the opportunity to reallocate rebates after the release of the Part D national average bid amount and regional PPO benchmarks. Appendix E contains rebate reallocation and rounding rules, including the following:

- A description of the rebate reallocation period.
- The types of benefit changes that are permitted during the rebate reallocation period.
- A summary of the circumstances under which rebate allocation is required, permitted, or not permitted.
- Limitations on significant changes to the BPT when rounding premiums.
- Specific rules for returning to the target Part D basic premium.
- Examples of rebate allocation and rounding.

It is important to note that for all plans, the initial June bid submission must reflect the desired level of premium rounding, since there are specific rules regarding the level of premium rounding permitted during the rebate reallocation period.

Plan Intention for Target Part D Basic Premium

Following CMS' publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional benchmarks, MA organizations may reallocate MA rebate dollars in certain MA-PD bids in order to return to the target Part D basic premium. MA-PD Plan sponsors must choose one of the following two options for the target premium: "Premium amount displayed in line 7d" or "Low Income Premium Subsidy Amount."

The target Part D basic premium is the Part D basic premium net of any MA rebate dollars that were applied to reduce (buy down) the premium; it does not include the Part D supplemental premium or the MA premium. Similarly, the low-income premium subsidy amount applies to the Part D basic premium and does not cover the cost of Part D supplemental benefits.

MA-PD Plan sponsors must choose a plan intention for the target Part D basic premium option in the initial June bid submission and cannot change the chosen target in a subsequent resubmission. CMS will consider only the option selected in the initial June bid submission as the plan's intention.

Point-of-Service (POS)

There is no separate service category for POS; therefore, POS base period experience data and projected allowed costs must be included in the appropriate service categories.

Preventive Services Incentives

The CY2010 Call Letter outlined requirements for items or services that a plan offers conditional to an enrollee taking some action (for example, receiving a flu shot) or participating in some program (for example, a smoking cessation program).

When an incentive program incurs a cost, then this cost must be priced in the bid. The projected PMPM cost of incentives must be combined with the cost of other non-covered benefits and entered in line q of the MA BPT. Note that combining the costs with "Other Non-Covered" does not change the nature of incentives, which cannot be "benefits", as explained in the CY2010 Call Letter. Supporting documentation is required with the initial June bid submission.

Rebate Allocations

The following rules apply for rebate allocations in the initial June bid submission:

- The fifth column of Worksheet 6, Section IIIB shows the maximum amount that may be applied for each rebate option. Each rebate allocation cannot exceed the applicable maximum. Note that if the maximum value is negative (such as a negative Part D basic premium before rebates), then the rebate allocation must be zero.
- The total rebates allocated must equal the total rebates available. Plans are not permitted to under- or over-allocate rebates in total. This rule applies to all bids, including 800-series EGWP bids.
- No rebate allocations may be negative.
- Rebate allocations for "Reduce A/B Cost Sharing" and "Other A/B Mandatory Supplemental Benefits" are rounded by the BPT to two decimals.
- The rebate allocations for Part B premium, Part D basic premium, and Part D supplemental premium are rounded by the BPT to one decimal (that is, the nearest dime) due to withhold system requirements.
- Employer-only group bids (that is, "800-series" plans) cannot allocate rebates to Part D.
- MA-only bids cannot allocate rebates to Part D.
- Rebates allocated to buy down the Part B premium are subject to the maximum amount shown on Worksheet 6 when the BPT is released by CMS. See the "Part B Premium and Buydown" pricing consideration and the instructions for Worksheet 6, Section II, for further information about rebates applied to the Part B premium.

Regional Preferred Provider Organizations (RPPOs)

Part B-Only

An RPPO plan must cover enrollees eligible for both Part A and Part B of Medicare. See Chapter 1 of the *Medicare Managed Care Manual* (MMCM), which can be found at: http://www.cms.gov/Manuals/IOM/itemdetail.asp? filterType=none& filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326 .

Intra-Service Area Rate (ISAR) Factors

In the event that the variation in the MA rates is not an accurate reflection of the variation in a plan's projected costs in its service area, CMS will consider allowing MA

organizations, on a case-by-case basis, to request that payment rates for RPPOs be developed using plan-provided geographic intra-service area rate (ISAR) factors. See the instructions for Worksheet 5 for more details on ISAR factors.

Related-Party Agreements (Medical and Non-Benefit)

The requirements for related-party agreements apply to a Plan sponsor that enters into any type of medical or service agreement involving a parent company and subsidiary or between subsidiaries of a common parent. CMS requires Plan sponsors to disclose all related-party agreements at the time of bid submission and to prepare the bid in accord with the guidance below for each related-party agreement identified.

The level of disclosure of related-party medical and service agreements must demonstrate that the operating results and financial positions for organizations participating in such agreements are not significantly different from the operating and financial arrangements that would have been achieved in the absence of the relationships.

A Plan sponsor in a related-party agreement with an organization that does not have an agreement with an unrelated party must prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. A Plan sponsor in this type of agreement must—

- Disclose the related-party agreement to CMS at the time of bid submission.
- For purposes of completing the BPT, consider the gain/loss and non-benefit expense of the related party to be those of the sponsor. For example, the Plan sponsor cannot allocate all administrative costs in the related-party agreement to non-benefit expense.
- Develop the medical, gain/loss and non-benefit expense of the related-party subcontractor in accord with these Instructions for completing the bid pricing tool.
- Support the development of the gain/loss and the actual costs associated with the medical and non-benefit expense as required by these instructions for completing the bid pricing tool.

A Plan sponsor in a related-party agreement with an organization that has an agreement with an unrelated party must either (i) demonstrate that fees associated with the sponsor's related-party transaction are comparable to the fees between the related-party organization and other unrelated parties of similar size and market position to the Plan sponsor, or (ii) prepare the BPT in a manner that does not recognize the independence of the subcontracted related party.

To demonstrate that fees associated with a related-party transaction are comparable to the fees between the related-party organization and other unrelated parties of similar size and market position, a Plan sponsor must—

- Disclose the related-party agreement to CMS at the time of bid submission.
- Provide a written document at the time of bid submission fully explaining the manner in which the terms of one or more of the agreements between the related-party organization and other unrelated parties and the associated fees are comparable.
- Prepare the BPT in a manner that recognizes the independence of the subcontracted related party by allocating all medical expenses and administrative costs in the related-party agreement to medical expenses and non-benefit expense, respectively.

A Plan sponsor in a related-party agreement with an organization that has an agreement with an unrelated party and chooses to prepare the BPT in a manner that does not recognize the independence of the subcontracted related party must—

- Disclose the related-party agreement to CMS at the time of bid submission.
- Prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. For purposes of completing the BPT, the Plan sponsor must consider the gain/loss and non-benefit expense of the related party to be those of the sponsor. The Plan sponsor cannot allocate all administrative costs in the related-party agreement to non-benefit expense.
- Develop the medical, gain/loss and non-benefit expense of the related-party subcontractor in accord with these instructions for completing the bid pricing tool.
- Support the development of the gain/loss and the actual costs associated with the medical and non-benefit expense as required by these instructions for completing the bid pricing tool.

To satisfy proprietary concerns, CMS can initiate separate contact with the Plan sponsor and subcontracted related party when addressing related-party issues in the bid. Plan sponsors interested in this level of discussion must request it and identify a point of contact at the related party at the time of bid submission.

Regardless of the bidding approach, Plan sponsors must substantiate all information presented in the BPT pertaining to related-party agreements even when that information is held by the related party.

Risk Score Development for CY2013

The projected CY2013 risk score must—

- Be based on the risk model used in payment years 2009 through 2013.
- Reflect plan-specific coding trend.
- Reflect population changes.
- Include the appropriate MA coding pattern differences adjustment factor.
- Be adjusted for FFS normalization.
- Include a frailty factor, if applicable.
- Be consistent with the development of projected medical expenses.

Risk Score Definitions and Information Sources

CMS Hierarchical Condition Categories (CMS-HCC) Risk Model

The version of the CMS-HCC risk model that will be used in CY2013 was initially used in CY2009. Additional information on the CMS-HCC model, including the 2013 normalization factor, is contained in the 2013 payment notice.

Normalization Factor

The risk scores used in payment for each plan enrollee will be divided by a factor, known as the FFS normalization factor for 2013. This adjustment accounts for the expectation of higher intensity of coding in the aggregate risk scores for the contract

year versus the model denominator year (2007) and is designed to bring the average risk score back to 1.0. Accordingly, the projected risk scores in the CY2013 bids must reflect the CY2013 normalization factor of 1.079.

MA Coding Pattern Differences Adjustment Factor

In addition to normalization, the projected risk scores in the CY2013 bids must reflect the MA coding pattern differences adjustment factor. This adjustment accounts for the difference in diagnostic coding between MA and FFS. The CY2013 MA coding pattern differences adjustment is 3.41 percent. Accordingly, the projected CY2013 normalized risk scores must be multiplied by 0.9659.

Risk Adjustment Information Sources

The following materials can be found on the "Medicare Advantage Rates and Statistics" page of the CMS website at http://www.cms.gov/MedicareAdvtgSpecRateStats/:

- "Announcement of Calendar Year (CY) 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies"
- "Advance Notice of Methodological Changes for Calendar Year (CY) 2013 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2013 Draft Call Letter"
- "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter"

See the links under "Risk Adjustment," "Announcements & Documents," and "Ratebooks & Supporting Data."

Additional information on the risk adjustment process can be found at http://www.csscoperations.com/.

Risk Score Calculation Approaches

Preferred Methodology

The preferred method for projecting the 2013 risk scores is use of the CMS-HCC risk scores for the risk model provided by CMS in—

- The plan-level data for the July 2011 enrollee cohort with retroactive enrollment and status adjustments; or
- The beneficiary-level file containing twelve months of 2011 membership with retroactive enrollment adjustments and status adjustments.

The plan-level data are available under the "Risk Adjustment" link on the HPMS Home page. (Note: You must have HPMS user access to view this information. The HPMS weblink is either https://32.90.191.19/hpms/secure/home.asp or https://gateway.cms.hhs.gov, depending on your firm's connection method.) The risk score data posted in HPMS are accompanied by technical notes to assist actuaries with understanding the material presented.

There are several advantages to using the 2011 HCC risk scores in the projection of the CY2013 risk score:

- They are consistent with the base-period medical expenses.
- They require no adjustment for seasonality.
- They reflect the most complete MA diagnosis data for 2010 dates of service submitted through January 31, 2012, which is the final reporting deadline for this period.
- They are based on the risk model to be used in 2013.

Please note that since the HPMS reported scores are based on a mid-year cohort using full calendar-year data with nearly complete run-out, they do not require explicit adjustment for (i) transition from lagged to non-lagged diagnosis data, (ii) incomplete reporting of diagnosis data, and (iii) seasonality. However, the starting risk score is to be projected from 2011 to 2013 with explicit adjustment for the following factors:

- Plan-specific coding trend.
- Changes in plan population.
- Other appropriate factors.

Finally, the projected risk scores must be normalized by dividing by the 2013 FFS normalization factor and by adjusting for MA coding pattern differences.

Alternate Approaches

An alternate method for the development of risk scores may be appropriate if the plan was first offered in 2012, if there was limited enrollment in 2011, or if there were significant changes in plan or enrollment characteristics between 2011 and 2012.

If a Plan sponsor chooses to develop its risk score by using a methodology different from that preferred by CMS, then, depending on the starting point, the following adjustments must be considered:

- Conversion to a raw risk score.
  - If the starting risk score is normalized, as it is when beginning with MMR data, then the certifying actuary may consider converting the starting risk score to a raw (un-normalized) risk score before making other adjustments.
  - Note that conversion from 2012 MMR data must adjust for both the normalization factor and the MA coding intensity factor.
- Impact of lagged versus non-lagged diagnosis data.
  - If the starting risk score is based on lagged diagnosis data, as it is when the initial risk scores are used, then an adjustment is required to transition the scores from lagged to non-lagged. An example is a starting point of March 2012 MMR data, which contain risk scores based on the July 2010 to June 2011 diagnosis data.
- Run-out of diagnosis data.
  - If the starting risk score is based on incomplete diagnosis data, as it may be when the starting point is diagnosis data and will be when the starting point is MMR data, then an adjustment factor is required to transition the scores from incomplete to complete diagnosis data. Starting risk scores from MMR data will not reflect the final reconciliation.

- Seasonality.
  - If the starting risk score is based on membership that is other than the July cohort or a full calendar-year cohort, then an adjustment for enrollment seasonality must be made.
- Risk model change.
  - If the starting risk scores are calculated using a risk model other than that to be used for payment for contract years 2009 through 2013, then an adjustment for the risk model change must be made.
- Plan-specific coding trend.
- Population changes.
- Other appropriate factors.

Once projected to CY2013, the scores must be normalized by dividing by the 2013 FFS normalization factor and by adjusting for the MA coding pattern differences adjustment factor. Note that, if a nominal or actual risk score associated with a different model calibration year is being normalized, the contract year 2013 FFS normalization factor is not appropriate and must be adjusted.

Supporting documentation that clearly demonstrates consistency with the preferred approach is required.

Manual Rating Approach

For plans that are priced using a manual rating approach, risk scores must be estimated based on the expected medical expenses for the plan's projected enrollees. Further, the risk scores for new plans must be developed in a manner consistent with the latest CMS-HCC model.

Service Area Changes

The initial bid submission must reflect pending service area expansions and changes. The user must enter county-level data on Worksheet 5 for each county in the proposed service area. If the pending request is later denied, then the Plan sponsor must resubmit a BPT that includes only the approved counties. The revised bid values must reflect only the change in the service area.

Skilled Nursing Facility

MA regulation 42 CFR §422.101(c) states that "MA organizations may elect to furnish, as part of their Medicare covered benefits, coverage of post hospital SNF care . . . in the absence of prior qualifying hospital stay that would otherwise be required for coverage of this care." Users may price the waiver of prior hospitalization requirement as a Medicare-covered benefit.

Supporting Documentation

In addition to the BPT and actuarial certification, organizations must submit supporting documentation for every bid. See Appendix B for a description of the supporting documentation requirements, including content, quality, and timing.

III. DATA ENTRY AND FORMULAS

This section contains line-by-line instructions for completing the Medicare Advantage (MA) Bid Pricing Tool (BPT) and the Medical Savings Account (MSA) BPT. It also describes the formulas for calculated cells.

MEDICARE ADVANTAGE

To complete the MA bid form, organizations must provide a series of data entries on the appropriate form pages.

The MA bid form is organized as outlined below:

- Worksheet 1 – MA Base Period Experience and Projection Assumptions
- Worksheet 2 – MA Projected Allowed Costs PMPM
- Worksheet 3 – MA Projected Cost Sharing PMPM
- Worksheet 4 – MA Projected Revenue Requirement PMPM
- Worksheet 5 – MA Benchmark PMPM
- Worksheet 6 – MA Bid Summary
- Worksheet 7 – Optional Supplemental Benefits

All worksheets must be completed, with the following exception: if the plan does not offer any optional supplemental benefit packages, then Worksheet 7 may be left blank.

MEDICAL SAVINGS ACCOUNT

Appendix H provides additional guidance in completing the MSA BPT for MSA plans. Appendix H highlights only the differences between the MSA BPT and the MA BPT.

DATA ENTRY

Do not leave a field blank to indicate a zero amount. If zero is the intended value, then enter a "0" in the cell.

MA WORKSHEET 1 – MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

The purpose of Worksheet 1 is to capture bid-specific experience for the base period, regardless of the level of enrollment and credibility, and to summarize the key assumptions used to project allowed costs to the contract period.

- Section I contains general plan information that will be displayed on all MA BPT worksheets.
- Section II captures base period background information.
- Section III summarizes the base period data for the plan.
- Section IV captures the factors used to project the base period data to the contract period.
- Section V contains a text field that describes other utilization factors and/or additive factors used in Section IV.
- Section VI contains a summary of the base period data.

Section I must be fully completed for all bids. (Note that some fields may be pre-populated by the Plan Benefit Package (PBP) software.) Sections II through VI must be completed for all plans with experience data for 2011 regardless of the level of enrollment.

SECTION I – GENERAL INFORMATION

The fields of Section I have been formatted as the "General" format in Excel, in order to support the functionality to link spreadsheets. Therefore, certain numeric fields, such as Plan ID, Segment ID, and Region Number, must be entered as text (that is, using a preceding apostrophe) and must include any leading zeros. All fields in Section I must be completed; none can be left blank.

Line 1 – Contract Number

Enter the contract number for the plan. The designation begins with a capital letter H (local plan), R (regional Preferred Provider Organization plan), or E (Employer/Union Direct Contract Private Fee-for-Service) and includes four Arabic numerals (for example, H9999, R9999, E9999). Be sure to include all leading zeros (for example, H0001).

Line 2 – Plan ID

The Plan ID (accompanied by the corresponding contract number) forms a unique identifier for the plan benefit package being priced in the bid form. Plan IDs contain three Arabic numerals. This field must be entered as a text input (that is, must include a preceding apostrophe) and must include any leading zeros (for example, '001).

If the bid is for a plan that is offered only to employer or union groups, then the Plan ID will be 800 or higher. This plan may be referred to as an "800-series plan," a "group plan," an "employer/union-only group waiver plan (EGWP)," or an "employer-only group plan."

Line 3 – Segment ID

If the bid is for a "service area segment" of a local plan, enter the segment ID. This field must be entered as a text input (that is, must include a preceding apostrophe) and must include any leading zeros (for example, '01).

Line 4 – Contract Year

This cell is pre-populated with the calendar year to which the contract applies.

Line 5 – Organization Name

Enter the organization's legal entity name. This information also appears in HPMS and the PBP.

Line 6 – Plan Name

Enter the plan name of the plan benefit package. This information also appears in HPMS and the PBP.

Line 7 – Plan Type

Enter the type of MA plan. The valid options are listed in the table below. The MA bid form is not completed for MSA, Cost, and PACE plans. There is a separate MSA Bid Pricing Tool.

Note that an MA organization must offer at least one benefit plan (of any plan type) that includes Part D coverage for each service area. This requirement does not apply to private-fee-for-service (PFFS) plans, which can be offered in a service area without Part D coverage.

Type of Plan	Plan Type Code
Local Coordinated Care Plans:	
Health Maintenance Organization (HMO)	HMO
Religious Fraternal Benefit HMO	RFB HMO
Religious Fraternal Benefit HMO with a Point-of-Service (POS) Option	RFB HMOPOS
HMO with a POS Option	HMOPOS
Provider-Sponsored Organization (PSO) with a State License	PSO State License
Religious Fraternal Benefit with a State License	RFB PSO State License
Preferred Provider Organization (PPO)	LPPO
Religious Fraternal Benefit PPO	RFB LPPO
Regional Coordinated Care Plan:	
Regional Preferred Provider Organization (RPPO)	RPPO
Private Fee-for-Service Plans:	
Private Fee-for-Service (PFFS)	PFFS
Religious Fraternal Benefit PFFS	RFB PFFS
Employer/Union Direct Contract Private Fee-for-Service Plan:	
Employer/Union Direct Contract PFFS	ED PFFS
Employer/Union Direct Contract LPPO	ED LPPO
Demonstration Plan:	
Continuing Care Retirement Community (CCRC)	CCRC

Line 8 – MA-PD

If the plan is offering Part D benefits during the contract year (and is therefore submitting a separate Part D bid form for the same Plan ID), enter "Y". Otherwise, enter "N".

Line 9 – Enrollee Type

If the bid prices a plan covering enrollees eligible for both Part A and Part B of Medicare, enter "A/B". If the bid prices a plan covering enrollees eligible for Part B only, enter "PART B ONLY". (See Appendix C for additional information regarding Part B-only plans.)

If the plan type equals "RPPO", then the enrollee type must equal "A/B".

Line 10 – MA Region

If the MA plan is a regional PPO (that is, plan type equals RPPO), then input the region number associated with the region that the plan will cover. This field must be entered as a text input (that is, must include a preceding apostrophe) and must include any leading zeros (for example, '01).

For regional PPO plans, valid entries are shown in the following table:

Region	Description
01	Northern New England (New Hampshire and Maine)
02	Central New England (Connecticut, Massachusetts, Rhode Island, and Vermont)
03	New York
04	New Jersey
05	Mid-Atlantic (Delaware, District of Columbia, and Maryland)
06	Pennsylvania and West Virginia
07	North Carolina and Virginia
08	Georgia and South Carolina
09	Florida
10	Alabama and Tennessee
11	Michigan
12	Ohio
13	Indiana and Kentucky
14	Illinois and Wisconsin

Region	Description
15	Arkansas and Missouri
16	Louisiana and Mississippi
17	Texas
18	Kansas and Oklahoma
19	Upper Midwest and Northern Plains (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming)
20	Colorado and New Mexico
21	Arizona
22	Nevada
23	Northwest (Idaho, Oregon, Utah, and Washington)
24	California
25	Hawaii
26	Alaska

Line 11 – Actuarial Swap or Equivalences Apply

If an individual-market plan will use actuarial swaps or equivalences for employer or union groups, enter "Y". Otherwise, enter "N". (See Appendix D for further information on using swaps or equivalences.)

Line 12 – SNP

If the plan is a Special Needs Plan (SNP), enter "Y". Otherwise, enter "N".

Line 13 – Region Name

No user input is required. This field displays the region name, based on the region number entered in line 10.

Line 14 – SNP Type

If the plan is a Special Needs Plan, enter the SNP type. Valid options are "Institutional", "Dual-Eligible", or "Chronic or Disabling Condition". This entry must match the SNP type in the PBP.

Line 15 – EGWP

No user input is required. This field displays a yes/no indicator based on the plan ID entered in line 2.

SECTION II – BASE PERIOD BACKGROUND INFORMATION

Line 1 – Time Period Definition

CMS requires base experience data to be based on claims incurred in calendar year 2011 and generally expects at least 30 days of paid claims run-out; 2 - 3 months of paid claim run-out is preferable. See the "Pricing Considerations" section of these instructions for more information.

The incurred dates are pre-populated on the first two lines, as 1/1 through 12/31 for the 2 years prior to the contract year. Enter the "paid through" date on the third line. For example, if the data reflect payment information through February 2012, then the "paid through" date is 2/28/2012.

Line 2 – Member Months

Enter the total member months represented in the base period experience, excluding ESRD enrollees for the time period that enrollees are in ESRD status based on CMS eligibility records and excluding hospice enrollees for the time period that the enrollees are in hospice status.

Then enter the subset of member months that represents the non-DE# enrollees. The DE# subset will be calculated as the difference between the total and the non-DE# amounts entered.

The "member months" fields must not be left blank.

Line 3 – Risk Score

Enter the normalized risk score for the non-ESRD and non-hospice members of the population represented in the base period data using the CMS- HCC risk model for payment in CY2011.

Also enter the risk score for the non-DE# subset. The DE# subset will be calculated based on the total and non-DE# amounts entered. If DE# members equals zero, then the non-DE# risk score must equal the total risk score.

Line 4 – Completion Factor

Enter the multiplicative factor used to adjust the paid data to an incurred basis. The base period data must represent the best estimate of incurred claims for the time period, including any unpaid claims as of the "paid through" date. The factor entered must be the amount to adjust

only the portion of paid claims that requires completion (that is, omit capitations from the calculation of this factor).

For example, assume the following:

Incurred Date	1/1/2011 – 12/31/2011
Paid Through Date (PTD)	2/28/2012
Capitation Payments	$100
PTD Claims Requiring Completion	$400
Estimate of Unpaid 2011 Claims as of 2/28/2012	$30
Total Incurred Claims for 2011	$530

The Completion Factor would be calculated as:
Completion Factor = (400 + 30) ÷ 400 = 1.075

Line 5 – Plan/Segments Included in Base Period Data

Enter the contract number and Plan ID (in the format H9999-999) of the plan for the base period data. If the segment is "01" or greater, include the segment ID (H9999-999-01). CMS expects that the contract number, Plan ID, and segment ID, if applicable, for the base period data will be the same as that shown in Section I, except for Plan ID changes and plan cross-walks. In the second column, input each plan's member months. The sum of the member months entered must equal the total member months reported in line 2.

Plan IDs are to be reported in descending order of member months, such that the plan with the largest member months is listed first. For example:

5. Plans in Base	Contract-Plan ID	Member Months
	a. H9999-032	5,000
	b. H8888-004-02	1,000
	c.	
	d.	

If members of more than eight plans are cross-walked into the Plan ID of the bid, then the Plan sponsor must submit supporting documentation that provides the base period member months for each plan included in the data. In this situation, Plan sponsors may enter "All Other" for the contract number/Plan ID indicated in the last line.

Line 6 – Base Period Description

Use the text box provided to briefly describe changes in the benefit plan, service area, or contract number/Plan ID/segment ID from the base period to the contract year.

SECTION III – BASE PERIOD DATA (AT PLAN'S RISK FACTOR) FOR 1/1/2011 – 12/31/2011

Section III summarizes the base period data by benefit service category.

In lines a through r:

- ✓ **Column c, lines a through r – Service Category**

  The benefit service categories are displayed in column c.

✓ **Column d, lines a through r – Net PMPM**

Enter the net medical PMPM for each of the benefit service categories for the base period.

✓ **Column e, lines a through r – Cost Sharing**

These fields are calculated automatically, as the difference between column i (allowed PMPM) and column d (net PMPM). The values must be greater than or equal to zero. Line r, COB, must equal zero.

✓ **Column f, lines a through q – Utilization type**

Column f displays the utilization types entered on Worksheet 2. Utilization types are required inputs on Worksheet 2, whether the pricing is based on base period experience data or manual rates.

✓ **Column g, lines a through q – Annualized Utilization/1,000**

Enter the annualized utilization per thousand enrollees for each of the benefit service categories for the base period data. The utilization/1000 must be reported consistently with the utilization type displayed in column f.

✓ **Column h, lines a through q – Average Cost**

These cells are calculated automatically using the utilization provided in column g and allowed PMPM provided in column i.

✓ **Column i, lines a through r – Allowed PMPM**

Enter the allowed PMPM by service category for the base period. Input any COB/Subrogation offsets to costs as a negative number, since line r will be added to total medical expenses.

Line s – Total Medical Expenses

Calculated automatically as the sum of lines a through r. Value should be greater than zero if base period member months are greater than zero.

Line t – Subtotal Medicare-Covered Service Categories

Calculated automatically as the sum of lines a through k.

SECTION IV – PROJECTION ASSUMPTIONS

Section IV contains the utilization, average unit cost, and other adjustment assumptions to project the base period data to the contract period. The values in columns j through n are the total adjustment factors from the base period to the contract period, not annual trend rates. For example, assume that the base period is calendar year 2011 and that the contract year is 2013. If the utilization trend is 5 percent from 2011 to 2012 and 6 percent for projecting 2012 to 2013, then enter "1.113" in column j (1.05 x 1.06).

In lines a through r:

✓ **Column j – Utilization Adjustment – Utilization/1,000 Trend**

Enter the utilization trend factor from the base period to the contract period by service category. Entering 1.000 would indicate 0 percent trend. Do not leave blank. Do not enter zero (0).

✓ **Column k – Utilization Adjustment – Benefit Plan Change**

Enter the multiplicative adjustment factor for any benefit plan changes (for example, increase in coverage level from base period to contract period) that affect the base period utilization by service category. Entering 1.000 would indicate 0 percent change. Do not leave blank. Do not enter zero (0).

✓ **Column l – Utilization Adjustment – Population Change**

Enter any expected demographic or morbidity changes that are necessary to adjust the base period data to the contract period. The population change adjustment entered in column l of Section IV must be consistent with the development of the CY2013 risk score. Entering 1.000 would indicate 0 percent change. Do not leave blank. Do not enter zero (0).

✓ **Column m – Utilization Adjustment – Other Factor**

Enter any other utilization factor adjustments by service category. Describe the reason for any adjustments in Section V if a factor other than 1.000 is used. An example of the use of this factor would be to adjust the base period service area to the contract year service area. Entering 1.000 would indicate 0 percent adjustment. Do not leave blank. Do not enter zero (0).

✓ **Column n – Unit Cost Adjustment – Provider Payment Change**

Enter the unit cost adjustments for expected changes in provider payments from the base period to the contract period by service category. Entering 1.000 would indicate 0 percent trend. Do not leave blank. Do not enter zero (0).

✓ **Column o – Unit Cost Adjustment – Other Factor**

Enter any other factors for unit cost adjustments by service category. Describe the reason for any adjustments in Section V if a factor other than 1.000 is used. Entering 1.000 would indicate 0 percent adjustment. Do not leave blank. Do not enter zero (0).

✓ **Columns p and q – Additive Adjustments**

Use these columns to reflect adjustments that are additive; adjustments in columns j through o are multiplicative factors. For example, a benefit that is no longer being offered, but is included in the base period data, might need to be deleted/removed. In this case, enter the adjustment as a negative number in column q. For benefits that need to be added, if they are not included in the base period experience data but will be offered in the contract period, utilize the manual rates section of Worksheet 2.

Describe the reason for any additive adjustments in Section V.

SECTION V – DESCRIPTION OF OTHER UTILIZATION ADJUSTMENT FACTOR, OTHER UNIT COST ADJUSTMENT FACTOR, AND ADDITIVE ADJUSTMENTS

Use this "text box" field to describe the reason for using a multiplicative factor other than 1.000 in columns m and o, and any additive adjustments entered in columns p and q.

SECTION VI – BASE PERIOD SUMMARY FOR 1/1/2011 – 12/31/2011 (EXCLUDES OPTIONAL SUPPLEMENTAL)

Section VI contains a summary of the actual base period revenue and expenses. This section must be completed consistently with the "Plans in Base" information (reported in Section II line 5) and consistently with the information reported in Section III.

Please note that Section VI must be completed in total dollars, and it must include all beneficiaries (that is, ESRD, hospice, and all other). To reiterate: the revenue (line 3), net medical expenses (line 4), and non-benefit expenses (line 7e) must include ESRD and hospice beneficiaries in addition to all other beneficiaries.

Section VI must not include amounts that are entered in Worksheet 1 of the Part D bid pricing tool. (For example, do not include MA rebates applied to Part D premiums.)

Section VI must not include optional supplemental benefits.

This section must not be left blank.

Line 1 – CMS Revenue

This field captures MA revenue from CMS for the base period in total dollars. Enter bid-based MA payments and accruals from CMS, including rebates for the reduction of A/B cost sharing and other A/B mandatory supplemental benefits. The payment accrual must account for the final risk-adjustment reconciliation payment for CY2011, which will be received in mid-2012. Do not include rebates applied to Parts B and D premium buydowns. Also, report the CMS revenues gross of user fee reductions.

In the first column, enter the amount applicable for ESRD enrollees. In the second column, enter the amount applicable for hospice enrollees. In the third column, enter the amount applicable to all other enrollees. The sum total is displayed in the fourth column.

Line 2 – Premium Revenue

Enter the revenue from earned MA premiums for the base period in total dollars. Include premiums associated with Medicare-covered and all A/B mandatory supplemental benefits. Do not include premiums for optional supplemental benefits. Do not include Part D premiums.

In the first column, enter the amount applicable for ESRD enrollees. In the second column, enter the amount applicable for hospice enrollees. In the third column, enter the amount applicable to all other enrollees. The sum total is displayed in the fourth column.

Line 3 – Total Revenue

This line is calculated as the sum of lines 1 and 2.

Line 4 – Net Medical Expenses

Enter the net medical expenses for the base period in total dollars. Include net medical expenses associated with Medicare-covered and all A/B mandatory supplemental benefits. Do not include expenses for optional supplemental benefits, and do not include expenses for Part D benefits.

In the first column, enter the amount applicable for ESRD enrollees. In the second column, enter the amount applicable for hospice enrollees. In the third column, enter the amount applicable to all other enrollees. The sum total is displayed in the fourth column.

Line 5 – Member Months

Enter the base period member months.

In the first column, enter the amount applicable for ESRD enrollees. In the second column, enter the amount applicable for hospice enrollees. The third column displays the amount applicable to all other enrollees, which is the total member months entered in Section II. The sum total is displayed in the fourth column.

Line 6 – PMPMs

Lines 6a through 6d compute base period "per member per month" values for revenue, net medical expenses, non-benefit expenses, and gain/loss margin.

Line 7 – Non-Benefit Expenses

Enter into lines 7a through 7d the MA non-benefit expenses for the base period in total dollars. Line 7e computes the total MA non-benefit expenses.

Uncollected premiums must be included in line 7b ("Direct Administration").

Line 8 – Gain/Loss Margin

Calculated as MA revenue (line 3) less net medical expenses (line 4) less MA non-benefit expenses (line 7e).

Line 9 – Percentage of Revenue

Lines 9a, 9b, and 9c compute the percentage of MA revenue for net medical expenses, non-benefit expenses, and gain/loss margin for the base period.

MA WORKSHEET 2 – MA PROJECTED ALLOWED COSTS PMPM

This worksheet calculates the projected allowed costs for the contract year. For plans without fully credible experience, it will be necessary to input manual rate information. The service category lines are the same as those on Worksheet 1.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – PROJECTED ALLOWED COSTS

Lines 1 and 2 – Projected Member Months and Projected Risk Factor

The projected member months and projected risk factors are obtained from Worksheet 5 for total, non-DE#, and DE# members.

In lines a through r:

✓ **Column e – Utilization Type**

Enter the type of utilization in column e for each benefit category that contains PMPM costs in column o. Do not leave this column blank. If manual rates are not used, entries in this column are still required and are displayed on Worksheet 1.

For each service category line, enter the appropriate utilization type that reflects the annualized utilization/1000 enrollees entered in columns f and i. The valid utilization types are listed below. Note that the valid utilization types vary by service category, as indicated in the BPT cell labels.

- A – Admits
- D – Days
- BP – Benefit Period
- V – Visits
- P – Procedures
- T – Trips
- S – Scripts
- O – Other

✓ **Columns f through h – Projected Experience Rate**

Columns f through h are calculated automatically using the information provided in Sections III and IV on Worksheet 1. No user inputs are needed. Column f calculates the projected utilization, column g is the expected average cost, and column h is allowed PMPM for the contract period, projected based on base period experience data.

✓ **Columns i through k – Manual Rate**

For a plan with less than fully credible experience or no experience, enter manual rate information for the contract period, and provide a description of the source of the manual rate in line u.

- ✓ **Column i – Annual Utilization/1,000**

  Enter utilization/1000 assumptions by service category in column i for lines a through q. Do not leave the utilization type (column e) blank.

- ✓ **Column j – Average Cost**

  Average cost will be calculated automatically based on the entries in columns i and k.

- ✓ **Column k – Allowed PMPM**

  Enter PMPM amounts in column k.

✓ **Line r – COB/Subrogation (outside claim system)**

Enter any COB/Subrogation offsets to costs as a negative number, since line r will be added to total medical expenses.

✓ **Column l – Experience Credibility Percentage**

Enter the experience credibility percentage by service category in column l.

The percentage entered must be between 0 percent and 100 percent. This percentage must be between 0 percent and 99 percent if the plan is using a manual rate in the projection. The percentage must equal 100 percent if a manual rate is not being used in the projection.

Between lines s and t of column l, the BPT displays the credibility percentage that is calculated based on CMS guidance and the base period member months entered on Worksheet 1. If the credibility entered by the plan does not equal the CMS credibility, then supporting documentation must be uploaded to HPMS.

✓ **Columns m through o – Blended Rate**

Columns m through o calculate the blended contract year rate, based on the projected experience rate, the manual rate, and the credibility percentage.

Note that, in column o, if the allowed PMPM is greater than zero and a utilization type is not entered, the BPT results in an error. A utilization type must be entered in column e for all service categories in which allowed PMPMs are projected.

PMPM values in column o must be greater than or equal to zero, with the exception of line r (COB/Subrg.), which may be negative.

✓ **Columns p and q – Non-DE# and DE# Allowed PMPMs**

Columns p and q capture the separate allowed PMPM costs for non-DE# and DE# enrollees. Column p must be entered on a "per non-DE# member per month" basis, and column q must be entered on a "per DE# member per month" basis. The amounts entered in columns p and q are used on Worksheet 4.

The BPT contains validations such that the total allowed PMPM in column o must be approximately equal to the weighted average of the non-DE# and DE# PMPMs.

- For each service category, the PMPM value for the total population must be within $0.05 (5 cents) of the weighted average of the non-DE# and DE# PMPMs.

- The BPT will finalize only if the total PMPM for all enrollees is within $0.50 (50 cents) of the weighted average of the non-DE# and DE# PMPMs.

See the "Pricing Considerations" section of these instructions for more information on the reporting requirements of DE# pricing.

Enter any COB/Subrogation offsets to costs as a negative number, since line r will be added to total medical expenses.

PMPM values entered in columns p and q must be greater than or equal to zero, with the exception of line r (COB/Subrg.), which may be negative.

✓ **Column r – Percentage of Services Provided Out-of-Network**

Enter the percentage of total allowed costs that are expected to be provided out-of-network for each service line. Enter a 0 if zero percent is expected; do not leave the field blank to indicate 0 percent. The percentage entered must be between 0 percent and 100 percent.

If the plan has OON cost sharing PMPM on Worksheet 3, or is an RPPO plan type, then it is expected that the percentage of services provided out-of-network on Worksheet 2 will be greater than 0 percent.

Line s – Total Medical Expenses

Calculated automatically as the sum of lines a through r. Values must be greater than or equal to zero.

Line t – Subtotal Medicare-Covered Service Categories

Calculated automatically as the sum of lines a through k. Values must be greater than or equal to zero.

Line u – Manual Rate Description

Use the text box to describe the general approach to manual rating, including a description of the source of the manual rate. This description is in addition to the required supporting documentation (see Appendix B). If the experience credibility used is less than 100 percent, then the manual rate description must not be left blank.

MA WORKSHEET 3 – MA PROJECTED COST SHARING PMPM

Worksheet 3 summarizes the projected MA cost sharing for the contract year and includes both in-network and out-of-network cost sharing.

See the "Pricing Considerations" section of these instructions for more information on cost sharing in general and the cost sharing for DE# beneficiaries.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – MAXIMUM COST SHARING PER MEMBER PER YEAR

The responses to the plan-level (out-of-pocket) OOP maximum drop-down questions depend on how Section D of the Plan Benefit Package (PBP) is completed and must be—

- "No" if the corresponding in-network, out-of-network, or combined (catastrophic) plan-level maximum enrollee OOP cost is blank in the PBP or if the PBP field is not applicable.
- "Yes" if the corresponding in-network, out-of-network, or combined plan-level maximum enrollee OOP cost is entered in the PBP. The PBP amount must be entered in the corresponding amount field on the BPT.

The responses to the plan-level OOP maximum drop-down questions are summarized below by type of plan:

- For HMO plans enter—
  - "Yes" for the plan-level in-network OOP maximum.
  - "No" for the plan-level out-of-network and combined OOP maximum.
- For HMO POS plans enter—
  - "Yes" for the plan-level in-network OOP maximum.
  - "Yes" or "No" for the plan-level out-of-network or combined OOP maximum, consistent with the PBP.
- For local PPO and regional PPO plans enter—
  - "Yes" for the plan-level in-network and combined OOP maximums.
  - "Yes" or "No" for the plan-level out-of-network OOP maximum, consistent with the PBP.
- For full network PFFS and partial network PFFS plans enter—
  - "Yes" for the plan-level combined OOP maximum.
  - "Yes" or "No" for the plan-level in-network and out-of-network OOP maximums, consistent with the PBP.
- For non-network PFFS plans enter—
  - "Yes" for the plan-level combined OOP maximum drop-down question in the BPT. Note that this question corresponds to the non-network maximum enrollee out-of-pocket cost amount entered on the PBP.

- "No" for the plan-level in-network and out-of-network plan-level OOP maximums.

When the response to the OOP maximum drop-down question is "Yes", the entry in the OOP maximum amount field must be numeric and greater than or equal to zero.

Any service-level category OOP maximums must be described in column h and must not be considered plan level in Section II.

Line 1 – In-Network

In the first field, select "Yes" or "No" to the question "Is there a plan-level in-network OOP maximum?" If the answer is "Yes", then enter in the second field the maximum total dollar amount that a member could pay for in-network cost sharing for the contract year. This dollar amount must match the dollar amount entered in the in-network maximum enrollee OOP cost field in Section D of the PBP.

Line 2 – Out-of-Network

In the first field, select "Yes" or "No" to the question "Is there a plan-level out-of-network OOP maximum?" If the answer is "Yes", then enter in the second field the maximum total dollar amount that a member could pay for out-of-network cost sharing for the contract year. This dollar amount must match the dollar amount entered in the out-of-network maximum enrollee out-of-pocket cost field in Section D of the PBP.

Line 3 – Combined

In the first field, select "Yes" or "No" to the question "Is there a plan-level combined OOP maximum?" If the answer is "Yes", then enter in the second field one of the following amounts:

- For non-network PFFS plans, the maximum total dollar amount that a member could pay in the contract year for cost sharing. This dollar amount must match the dollar amount entered in the maximum enrollee out-of-pocket cost field in Section D of the PBP.
- For other plans, the maximum total dollar amount that a member could pay in the contract year for cost sharing both in- and out-of-network. This dollar amount must match the dollar amount entered in the combined (in-network and out-of-network) maximum enrollee out-of-pocket cost field in Section D of the PBP. Do not sum separate in-network and out-of-network OOP maximums.

Line 4 – Maximum Cost-Sharing Description

In the text box provided, briefly explain the methodology used to reflect the impact of maximum cost sharing on the PMPM values entered in Section III.

SECTION III – DEVELOPMENT OF CONTRACT YEAR COST SHARING PMPM (PLAN'S RISK FACTOR)

Section III summarizes the cost sharing for all services included in the plan benefit package.

The service categories are the same as presented in previous worksheets, except that line r (COB) has been omitted. Please note that for some service categories (for example, "Inpatient Facility"), there is more than one cost-sharing line available. A number of lines allow you to enter multiple cost-sharing items in a service category to better match the PBP. In addition to the lines presented, you may also use the ten blank lines at the bottom of the section to include additional cost-sharing items that do not fit into an already defined service category line item. Do not insert any additional rows.

The BPT allows for flexibility in entering cost-sharing information. Following are some examples:

Example 1: The PBP contains in-network inpatient cost sharing of $100 per day for both acute and psychiatric stays with no cost sharing maximum. Assume that the total in-network inpatient utilization/1000 is 2,000 days, 1,900 of which are for acute and the remaining 100 for psychiatric. There is no in-network cost sharing maximum. These figures could be reflected in the bid form in either of the following ways:

Option A:

Column d	Column g	Column j	Column k
Line a1 – Acute	1,900	$100.00	$15.83
Line a2 – Mental Health	100	$100.00	$ 0.83
Total	2,000	$100.00	$16.67

Option B:

Column d	Column g	Column j	Column k
Line a1 – Acute	2,000	$100.00	$16.67
Total	2,000	$100.00	$16.67

Example 2: The PBP has in-network professional copays of $10 for PCP, $20 for specialists excluding mental health (MH) services, $20 for MH group sessions, and $40 for individual MH sessions. There is no in-network cost sharing maximum. Assume that in-network office visit utilization is distributed as follows:

Type of Service	Utilization
PCP	5,000
Mental Health – Individual	50
Mental Health – Group	50
Other Spec	2,900
Total	8,000

Following are some of the options that could be used to complete the bid form:

Option A: Use the finest level of detail, with individual MH in line i3 and group MH in line i6.

Line – Description	Column g	Column j	Column k
Line i1 – PCP	5,000	$10.00	$4.17
Line i2 – Specialist excl MH	2,900	$20.00	$4.83
Line i3 – Mental Health	50	$40.00	$.17
Line i6 – Other	50	$20.00	$.08
Total	8,000	$13.88	$9.25

Note that one of the blank rows at the bottom of the form could also be used to enter one of the MH copays.

Option B: Same as Option A, but combine the individual and group MH copays onto line i3.

Line – Description	Col g	Col h	Col j	Col k
Line i1 – PCP	5,000	$10 per visit	$10.00	$4.17
Line i2 – Specialist excl MH	2,900	$20 per visit	$20.00	$4.83
Line i3 – MH	100	$40/visit for indiv MH sessions, $20/visit for group MH	$30.00	$.25
Total	8,000		$13.88	$9.25

Option C: Enter all services on one line (for example, i6).

Line – Description	Col g	Col h	Col j	Col k
Line i6	8,000	$10/visit PCP $20/visit non-MH specialist $20/visit for group MH $40/visit for indiv MH	$13.88	$9.25
Total	8,000		$13.88	$9.25

Column c – Service Category

This column is pre-populated for most of the available rows. When the blank rows at the bottom of the worksheet are used to provide detailed cost-sharing information, the valid entries are as follows:

- Inpatient Facility
- Skilled Nursing Facility
- Home Health
- Ambulance
- DME/Prosthetics/Supplies
- Outpatient (OP) Facility – Emergency
- OP Facility – Surgery
- OP Facility – Other
- Professional
- Part B Rx
- Other Medicare Part B
- Transportation (Non-covered)
- Dental (Non-covered)
- Vision (Non-covered)
- Hearing (Non-covered)
- Health & Education (Non-covered)
- Other Non-covered

Technical note: When the blank rows at the bottom of the worksheet are used, the service category entries must match those listed above exactly. If there is a typographical error in the entry, the BPT will not recognize the entered cost-sharing information on Worksheet 4.

Column d – Service Category Description

This column provides a description for many of the fixed-line cost-sharing items. For lines with multiple options (for example, "Inpatient Facility"), the description is intended to help you provide detailed information that can easily be checked against the PBP. You may input a description if you are using a blank row at the bottom of the worksheet to enter additional cost-sharing lines.

Column e – Measurement Unit Code

For each cost-sharing line, enter the appropriate measurement unit that reflects the projected utilization per 1,000 or PMPM value entered in column g. The valid utilization types are listed below. Note that the valid utilization types vary by service category, as indicated in the BPT cells.

- A – Admits
- D – Days
- BP – Benefit Period
- V – Visits
- P – Procedures
- T – Trips
- S – Scripts
- O – Other
- Coin – Coinsurance
- Ded – Deductible (used only for single-line items, such as per-benefit period deductibles; plan-level deductibles that apply to multiple service categories and the pricing impact are entered in the footnote and column f)

Column f – In-Network Effective Plan-Level Deductible PMPM

If there is an in-network plan-level deductible (which includes an in-network plan-level deductible for Part B-only), you must enter the effective amount of the deductible on each service category line affected. For each service that is subject to the plan-level deductible, enter an amount such that the sum total represents the effective PMPM value of the deductible.

Enter the actual in-network plan-level deductible amount (for example, $500) in the footnote. If an effective deductible is entered in column f, then an actual deductible must be entered in the footnote. The footnote area also includes drop-down questions about the applicability of plan-level deductibles for Part B-only.

Columns g through k – In-Network Cost Sharing after Plan-Level Deductible

These fields pertain to the in-network cost sharing priced in the BPT.

✓ **Column g – In-Network Util/1000 or PMPM**

Enter the projected in-network utilization/1000, or PMPM value in the case of coinsurance—

- For the time period for which the cost sharing applies.
- After the plan-level deductible has been satisfied.
- Before the impact of the OOP maximum.

✓ **Column h – In-Network Description of Cost Sharing/Additional Days/Benefit Limits**

Enter a description of the in-network cost sharing for each service category, including any benefit limits. This is a text field.

This BPT field must provide descriptions of all plan cost sharing contained in the PBP, including descriptions of all PBP benefits priced together within each BPT service category. These details are necessary since each BPT category may map to several PBP benefit categories.

Plan sponsors are to use this field to describe all in-network benefits priced in the BPT. The user must enter a description for each service category based on the following rules:

- Enter descriptions that are easily matched to the PBP.
- Enter cost sharing designed to match original Medicare cost sharing as "Medicare FFS".
- Show the specific cost sharing amount for each item included in the BPT line.
- Show both minimum and maximum cost-sharing amounts, if applicable.
- Even if there is no cost sharing for a particular service category, you must enter a comment indicating the zero cost-sharing arrangement (that is, "$0.00" or "0%"). Do not leave this column blank.

Acceptable formats for cost-sharing descriptions generally include PBP line number as shown in the following examples:

- "(4a) $50/visit, (4b) $25/visit"
- "(1a) $150, (9b) $150"
- "(1a) $150 days 1 - 5, $0 after day 5, unlimited coverage"
- "(17a) $100 eye exam every 2 years"
- "Medicare FFS"

Enter the actual plan-level deductible amount(s) (if applicable) in the footnote.

✓ **Column i – In-Network Effective Copay/Coinsurance before OOP Max**

Enter the projected effective in-network cost-sharing amount after the plan-level deductible has been satisfied and before the impact of the OOP max. This amount must represent either the effective copay (if utilization is entered in column g) or the effective coinsurance percentage (if PMPM is entered in column g).

Note that this cell is not used to calculate the in-network PMPM in column k. However, if a value is entered in column j, then a corresponding value must be entered in column i for each service category.

✓ **Column j – In-Network Effective Copay/Coinsurance after OOP Max**

Enter the projected effective in-network cost-sharing amount after the plan-level deductible has been satisfied and including the impact of the OOP max. This amount must represent either the effective copay (if utilization is entered in column g) or the effective coinsurance percentage (if PMPM is entered in column g). This cell is used to calculate the in-network PMPM in column k. The values in column j must be less than or equal to the corresponding values in column i.

Enter the PMPM pricing impact of the in-network OOP maximum in the footnote.

✓ **Column k – In-Network PMPM**

These cells are calculated automatically and reflect the projected cost-sharing value PMPM for in-network services, excluding the effective in-network plan-level deductible and including the impact of the OOP maximum. The formula uses the utilization or PMPM amounts in column g and the effective copay or coinsurance in column j.

- If the measurement unit is coinsurance ("Coin"), then the calculation is column g times column j.
- For measurement units other than coinsurance, the calculation is column g times column j divided by 12,000.

Enter the actual in-network plan-level deductible and the pricing impact of the in-network OOP maximum in the footnote.

Column l – Total In-Network Cost Share PMPM

These cells are calculated automatically as the sum of columns f and k. This column is the total projected cost sharing for in-network services.

Note that, in column l, if the cost sharing PMPM is greater than zero and a utilization type is not entered, the BPT result is an error. A utilization type must be entered in column e for all service categories into which cost sharing PMPMs are entered.

Column m – Out-of-Network Description of Cost Sharing/Additional Days/Benefit Limits

Enter a description for the out-of-network cost sharing of each service category. This is a text field. See the instructions for in-network cost sharing in line h for additional information.

This field must describe all out-of-network benefits priced in the BPT. Even if there is no cost sharing for a particular service category, you must enter a comment indicating the zero cost-sharing arrangement (that is, $0.00 copay or 0 percent coinsurance). For plans that have out-of-network benefits, this field must not be left blank.

Column n – Out-of-Network Cost Sharing PMPM

Enter the effective value of cost sharing for out-of-network benefits for each service category. This column must reflect the total projected cost sharing for all out-of-network services.

Enter the actual out-of-network plan-level deductible and the pricing impact of the out-of-network OOP maximum in the footnote.

Column o – Grand Total Cost Share PMPM (In-Network and Out-of-Network)

This column is calculated automatically as the sum of the in-network cost sharing (column l) and the out-of-network cost sharing (column n).

Footnotes

If a plan-level deductible is designed to match original Medicare cost sharing, enter the actual deductible as "Medicare FFS".

✓ **Column h**

In the first footnote, enter the actual combined (in-network and out-of-network) plan-level deductible (which includes a combined plan-level deductible for Part B-only), consistent with the PBP.

In the second footnote, consistent with the PBP, enter "Yes" or "No" to the question "Does the actual combined plan-level deductible apply to Part B-Only?"

✓ **Column k**

In the first footnote, enter the actual in-network plan-level deductible (which includes an in-network plan-level deductible for Part B-only), consistent with the PBP.

In the second footnote, consistent with the PBP, enter "Yes" or "No" to the question "Does the actual in-network plan-level deductible apply to Part B-Only?"

In the third footnote, enter the PMPM pricing impact of the in-network OOP maximum. This value must reflect the PMPM difference between the pricing for in-network cost sharing before and after the OOP maximum has been applied.

✓ **Column n**

In the first footnote, enter the actual out-of-network plan-level deductible (which includes an out-of-network plan-level deductible for Part B-only), consistent with the PBP.

In the second footnote, consistent with the PBP, enter "Yes" or "No" to the question "Does the actual out-of-network plan-level deductible apply to Part B-Only?"

In the third footnote, enter the PMPM pricing impact of the out-of-network OOP maximum. This value must reflect the PMPM difference between the pricing for out-of-network cost sharing before and after the OOP maximum has been applied.

MA WORKSHEET 4 – MA PROJECTED REVENUE REQUIREMENT PMPM

This worksheet uses the allowed costs (Worksheet 2) and cost sharing (Worksheet 3) to determine net medical costs in Section II. Below are the subsections contained in Section II:

- Subsection A - "Non-DE# (Non-Dual Eligible Beneficiaries AND Dual Eligible Beneficiaries with full Medicare cost sharing liability)."
- Subsection B - "DE# (Dual-Eligible Beneficiaries without full Medicare cost sharing liability)."
- Subsection C - "All Beneficiaries."

Subsection C is the weighted average total of subsections A and B.

Non-benefit expenses and gain/loss margin are entered in Section IIC to establish the plan's revenue requirements for the contract year. Values are allocated between Medicare-covered benefits and A/B mandatory supplemental benefits and reflect the plan's non-ESRD risk factor for the contract period. In Section III, the Plan sponsor must enter the projected member months for ESRD enrollees and may enter the projected ESRD "subsidy". ESRD enrollees must be excluded from all other sections of the BPT.

The Plan sponsor may use Section IV to provide the costs associated with additional "unspecified" benefits for employer/union-only group waiver plan (EGWP) bids. Section V captures projected Medicaid data for DE# beneficiaries.

See the "Pricing Considerations" section of these instructions for information on completing Worksheet 4 for DE# beneficiaries.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – DEVELOPMENT OF PROJECTED REVENUE REQUIREMENT

Subsection A – Non-Dual-Eligible Beneficiaries and Dual-Eligible Beneficiaries with Full Medicare Cost-Sharing Liability (Non-DE#)

The non-ESRD risk factor for non-DE# beneficiaries is obtained from Worksheet 5 and displayed at the top of this section.

In lines a through r:

✓ **Column e – Allowed PMPM for Total Benefits**

The allowed PMPM is obtained from column p of Worksheet 2.

✓ **Column f – Plan Cost Sharing for Total Benefits**

The total in-network and out-of-network cost sharing PMPMs are obtained from column o of Worksheet 3 for each service category (except for line r). If you enter additional cost-sharing lines on Worksheet 3, then you must verify that the total cost sharing on Worksheet 4 equals the total on Worksheet 3.

✓ **Column g – N/A**

This column is left intentionally blank; it is not applicable to this section.

✓ **Column h – Net PMPM for Total Benefits**

The net PMPM is calculated automatically as column e less column f. Values must be greater than or equal to zero.

✓ **Columns i and j – Percentage for Covered Services**

The PMPM amounts shown in columns e, f, and h reflect all benefits covered by the MA plan. In columns i and j, you must enter the expected percentages of these benefits that represent Medicare-covered. The percentages in column i are used to allocate allowed costs (column e) between Medicare-covered (column m) and A/B mandatory supplemental benefits. The percentages in column j are used to allocate the plan's cost sharing (column f) between plan cost sharing for Medicare-covered services (column l) and cost sharing for A/B mandatory supplemental benefits.

The percentage entered must be between 0 percent and 100 percent.

For services that are non-covered as defined, the percentage is defaulted to 0.0 percent (for example, line l, "Transportation Non-covered"). For all other services, the Plan sponsor must estimate the percentage of covered services for both the allowed costs and the cost sharing. Enter these percentages in columns i and j. If the plan's benefit for a service is richer than that under FFS Medicare, the percentage entered must be less than 100 percent.

Example:

The Plan sponsor estimates that 99.92 percent of the allowed PMPM in column e for outpatient facility emergency services is for Medicare-covered services and 0.08 percent is for A/B mandatory supplemental benefits, whereas 98.03 percent of the cost sharing PMPM in column f is for Medicare-covered services and 1.97 percent of the cost sharing is for A/B mandatory supplemental benefits. The entries in columns i and j would be as follows:

(c) (i) (j)

	% for Cov. Svcs	
Service Category	Allowed	Cost Sharing
f. OP Facility – Emergency	99.92%	98.03%

See Appendix C for instructions on completing columns i and j for Part B-only plans.

For the Medicare-covered service categories (lines a through k), the values entered in columns i and j must generate appropriate pricing for mandatory supplemental benefits in columns p through r, consistent with the PBP. In addition, the relationship of the PBP benefits and the BPT pricing is to be consistent with the suggested mappings contained in Appendix F. Any deviations from the suggested mappings must be documented in supporting exhibits. For example, if a plan covers additional inpatient hospital days, then, absent supporting documentation that identifies a different mapping,

the PMPM pricing for the non-covered inpatient services is to be represented in line a, column p, "Net PMPM for Additional Services."

✓ **Column k – FFS Medicare Actuarial Equivalent (AE) Cost-Sharing Proportions**

These values are populated automatically based on the enrollment projections entered in Worksheet 5.

✓ **Column l – Plan Cost Sharing for Medicare-Covered Services**

This column calculates the portion of the plan's cost sharing that is attributable to Medicare-covered benefits (calculated as column f times column j). This column is used to determine the reduction of A/B cost sharing in column q.

Plan cost sharing for Medicare-covered services is compared to Medicare FFS actuarially equivalent cost sharing in the BPT "red-circle" validations.

✓ **Columns m through o – Medicare-Covered using Actuarial Equivalent Cost Sharing**

These columns are calculated automatically and are the basis for the costs included in the "Plan A/B Bid."

✓ **Column m – Allowed PMPM**

The Medicare-covered allowed costs are calculated automatically based on the percentage of Medicare-covered benefits input in column i. Column m is calculated as column e times column i.

✓ **Column n – Fee-for-Service Medicare Actuarial Equivalent (AE) Cost Sharing**

The FFS Medicare AE cost sharing PMPMs are based on the proportions in column k. Column n is calculated as column k times column m.

✓ **Column o – Net PMPM**

Calculated as column m minus column n.

Columns p through r – A/B Mandatory Supplemental (MS) Benefits

These columns are calculated automatically and are the basis for the costs included in the A/B mandatory supplemental premium.

✓ **Column p – Net PMPM for Additional Services**

These amounts reflect the net costs (that is, allowed costs less enrollee cost sharing) for non-covered benefits. This column is calculated automatically as the allowed costs for non-covered benefits (column e minus column m) less the cost sharing for non-covered benefits (column f minus column l). These values must be greater than or equal to zero (except line r, COB, which may be negative).

✓ **Column q – Reduction of A/B Cost Sharing**

This column is the difference between FFS AE cost sharing and the plan cost sharing for Medicare-covered services, calculated automatically as column n minus column l. This reduction is sometimes referred to as the "FFS cost-sharing buydown."

✓ **Column r – Total A/B Mandatory Supplemental Benefits**

This column is calculated automatically as the sum of columns p and q.

Line s – Total Medical Expenses

The total medical expense is the sum of lines a through r, except for columns i, j, and k.

Subsection B – Dual-Eligible Beneficiaries without Full Medicare Cost-Sharing Liability (DE#)

The non-ESRD risk factor for DE# beneficiaries is obtained from Worksheet 5 and displayed at the top of this section.

In lines a through r:

✓ **Column e – Reimbursement plus Actual Cost Sharing for Total Benefits**

Calculated automatically as the sum of columns g and h.

✓ **Column f – Plan Cost Sharing for Total Benefits**

This column contains a formula that may be overwritten by the user. The default formula divides the non-DE# beneficiary cost sharing by the non-DE# allowed, and then multiplies by the DE# allowed from column q of Worksheet 2. See the "Pricing Considerations" section of these instructions for more guidance.

✓ **Column g – Actual Cost Sharing for Total Benefits**

Calculated automatically as the minimum of columns f and k.

✓ **Column h – Plan Reimbursement for Total Benefits**

Calculated automatically as column q from Worksheet 2 less column f.

✓ **Columns i and j – Percentage for Covered Services**

See instructions under Worksheet 4, subsection IIA, columns i and j.

✓ **Column k – State Medicaid Required Beneficiary Cost Sharing**

Enter values in accordance with the "Pricing Considerations" section of these instructions.

✓ **Column l – Actual Cost Sharing for Medicare-Covered Services**

Calculated automatically as column g times column j.

✓ **Columns m through o – Medicare-Covered using Medicaid Cost Sharing**

These columns are calculated automatically and are the basis for the costs included in the "Plan A/B Bid."

✓ **Column m – Allowed PMPM**

The Medicare-covered allowed costs are calculated automatically based on the percentage of Medicare-covered benefits input in column i. Column m is calculated as column e times column i.

- ✓ **Column n – Medicaid Cost Sharing**

  Calculated automatically as column k times column j.

- ✓ **Column o – Net PMPM**

  Calculated as column m minus column n.

Columns p through r – A/B Mandatory Supplemental (MS) Benefits

These columns are calculated automatically and are the basis for the costs included in the A/B mandatory supplemental premium.

- ✓ **Column p – Net PMPM for Additional Services**

  This column is calculated automatically as the allowed costs for non-covered benefits (column e minus column m) less the cost sharing (column g minus column l). These values must be greater than or equal to zero (except line r, COB, which may be negative).

- ✓ **Column q – Reduction of A/B Cost Sharing**

  This column is calculated automatically as column n minus column l.

- ✓ **Column r – Total A/B Mandatory Supplemental Benefits**

  This column is calculated automatically as the sum of columns p and q.

Line s – Total Medical Expenses

The total medical expense is the sum of lines a through r, except for columns i and j.

Subsection C – All Beneficiaries

The non-ESRD risk factor for total beneficiaries is obtained from Worksheet 5 and displayed at the top of this section.

In lines a through q and t:

- ✓ **Columns e through g – N/A**

  These columns are left intentionally blank; they are not applicable to this section.

- ✓ **Column h – Net PMPM for Total Benefits**

  The PMPM is calculated automatically as the weighted average of subsections A and B, based on projected enrollment in Worksheet 5.

- ✓ **Columns i through n – N/A**

  These columns are left intentionally blank; they are not applicable to this section.

- ✓ **Column o – Net PMPM for Medicare-Covered Benefits**

  The PMPM is calculated automatically as the weighted average of subsections A and B, based on projected enrollment in Worksheet 5.

Columns p through r – A/B Mandatory Supplemental (MS) Benefits

These columns are calculated automatically and are the basis for the costs included in the A/B mandatory supplemental premium.

✓ **Column p – Net PMPM for Additional Services**

The PMPM is calculated automatically as the weighted average of subsections A and B, based on projected enrollment in Worksheet 5.

✓ **Column q – Reduction of A/B Cost Sharing**

The PMPM is calculated automatically as the weighted average of subsections A and B, based on projected enrollment in Worksheet 5.

✓ **Column r – Total A/B Mandatory Supplemental Benefits**

This column is calculated automatically as the sum of columns p and q.

Line r – ESRD

This line is populated based on Section III.

Line s – Additional Benefits (employer bids only)

This line is populated based on Section IV.

Line u – Total Medical Expenses

The total medical expense is the sum of lines a through t. The value in column o is the net medical cost included in the "Plan A/B Bid." The value in column r is the net medical cost included in the A/B mandatory supplemental premium.

Line v – Non-Benefit Expenses

Enter the non-benefit expense information for total MA benefits in column h for the four categories listed below:

- Marketing & Sales
- Direct Administration
- Indirect Administration
- Net Cost of Private Reinsurance

The worksheet distributes the non-benefit expenses proportionately between Medicare-covered (column o) and A/B mandatory supplemental (column r) for each category. Non-benefit expenses are also distributed within A/B mandatory supplemental benefits between "Additional Services" (column p) and "Reduction of A/B Cost Sharing" (column q).

See the "Pricing Considerations" section of these instructions for more information regarding non-benefit expenses.

Lines v1 through v4 – Non-Benefit Expenses

Total non-benefit expenses are input in column h and allocated proportionately between Medicare-covered (column o) and A/B mandatory supplemental (column r). Note that the same proportion is used for each line item. The allocation is based on the relative proportion of the

plan's medical expense requirements for Medicare-covered ("bid") and A/B mandatory supplemental, excluding the PMPM impact of the ESRD subsidy.

- ✓ **Column h – Non-Benefit Expense PMPM for Total Benefits**

  Enter the PMPM by category. Lines v1, v2, and v3 must be greater than or equal to zero.

- ✓ **Column o – Non-Benefit Expense PMPM for Medicare-Covered**

  These values are calculated as column h minus column r.

- ✓ **Column r – Non-Benefit Expense PMPM for A/B Mandatory Supplemental**

  These values are calculated based on the relative proportion of A/B mandatory supplemental, excluding the impact of the ESRD subsidy.

Line v5, columns h, o, and r – Total Non-Benefit Expense

The sum of lines v1 through v4. The value must be greater than or equal to zero.

Line v5, columns p and q – Total Non-Benefit Expense for Additional Services and Reduction of A/B Cost Sharing

The total non-benefit expense for A/B mandatory supplemental benefits (column r) is allocated between additional services (column p) and reduction of A/B cost sharing (column q). The allocation is based on the relative proportions of additional services and reduction of A/B cost sharing, excluding the impact of the ESRD subsidy.

Line w – Gain/Loss Margin

Enter the projected PMPM for the gain/loss in column h for total MA services. Do not leave this field blank.

The gain/loss margin is distributed proportionately between Medicare-covered and A/B mandatory supplemental. The allocation is based on the relative proportions of the medical expense requirements for Medicare-covered and A/B mandatory supplemental, excluding the PMPM impact of the ESRD subsidy.

See the "Pricing Considerations" section of these instructions for more information regarding gain/loss margin.

Line x – Total Revenue Requirement

The sum of lines u (medical expense), v5 (non-benefit expense), and w (gain/loss margin). The value in column o is the total revenue requirement of the "Plan A/B Bid."

Line y – Percentage of Revenue (excluding ESRD line)

These lines calculate the ratio of net medical expense, non-benefit expense, and gain/loss margin as a percentage of revenue. These ratios exclude the PMPM impact of the ESRD subsidy.

SECTION III – DEVELOPMENT OF PROJECTED CONTRACT YEAR ESRD "SUBSIDY"

Section III allows for an adjustment to A/B mandatory supplemental benefits in line r of Section II. This adjustment is split into two sections: one for basic benefits and the other for supplemental benefits.

Non-ESRD CY Member Months

This value is obtained from Worksheet 5.

ESRD CY Member Months

All Plan sponsors must enter the projected CY ESRD member months. Do not leave this field blank. If no ESRD enrollees are expected during the contract period, then enter a zero (0) in this field.

Basic Benefits

See the "Pricing Considerations" section on ESRD for more information.

Supplemental Benefits

See "Pricing Considerations" section on ESRD for more information.

SECTION IV – FOR EMPLOYER BID USE ONLY ("800-SERIES")

This section may be used for employer/union-only group waiver plan bids ("800-series" Plan IDs) and employer/union direct contract private fee-for-service plans (that is, plan type equal to "ED PFFS") to provide CMS with the PMPM costs associated with additional "unspecified" benefits. These services may be funded by rebate dollars. Consistent with individual-market bids, all rebates available to the plan must be allocated on Worksheet 6.

See Appendix D for further information on group bids.

Line 1 – PMPM for Additional (Unspecified) Mandatory Supplemental Benefits

Enter the PMPM value of medical costs associated with additional "unspecified" benefits. The benefits represented by this value may be customized for each employer or union group that enrolls in the plan. See Appendix D for further guidance on the use of this field.

This value will be used in line s of Section IIC.

SECTION V – PROJECTED MEDICAID DATA FOR DE# BENEFICIARIES

This section contains two input cells: line 1, "Medicaid Projected Revenue," and line 2, "Medicaid Projected Cost (not in bid)." Entries must be reported on a "per DE# Member per Month" basis. See the "Pricing Considerations" section of these instructions for more guidance.

MA WORKSHEET 5 – MA BENCHMARK PMPM

This worksheet calculates the A/B benchmark and evaluates whether the plan realizes a savings or needs to charge a basic member premium.

Below is a brief description of the sections contained in this worksheet:

- Section I – General information entered on Worksheet 1.
- Section II – Summary of development of the benchmark and the bid.
- Section III – Summary of development of the savings or basic member premium.
- Section IV – Development of the regional A/B benchmark (including the statutory component of the regional benchmark). Applies to RPPO plan types only.
- Section V – Summary of Quality Bonus Rating information (from CMS).
- Section VI – Projected plan-specific information for counties within the service area.
- Section VII – Other Medicare information (populated based on the enrollment projection).

The A/B benchmark calculation is based on the following data elements:

- Service Area: Counties within the MA service area defined by their respective Social Security Administration (SSA) state-county codes.
- Projected Member Months (excluding ESRD and hospice): Projected non-ESRD non-hospice member months, reported by county.
- Projected Risk Factor (excluding ESRD and hospice): Projected average risk factor for non-ESRD non-hospice enrollees.
- Medicare Secondary Payer Adjustment Factor: Factor relative to all payments.
- For RPPOs, the mix of Medicare beneficiaries (nationally) between original Medicare and Medicare Advantage (used to weight the statutory and plan bid components of the regional A/B benchmark).
- Quality Bonus Rating (from CMS).

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – BENCHMARK AND BID DEVELOPMENT

Line 1 – Projected Member Months

The value for total projected member months (excluding ESRD and hospice) is obtained from Section VI. You must enter the projected non-DE# member months. The value for DE# member months is calculated as the difference between the total and the non-DE# amounts. See the "Pricing Considerations" section of these instructions for more guidance.

Line 2 – Standardized A/B Benchmark (at 1.000 Risk Score)

This value is obtained from Section IV for regional plans and from Section VI for local plans.

Line 3 – Medicare Secondary Payer (MSP) Adjustment

User input is required. Note that this field is formatted as a percentage; therefore, if the value is 2.53 percent, enter "2.53" or "0.0253". Do not leave this field blank. If zero percent is the projected value, then enter a "0" in this field. The value entered must be between 0 percent and 100 percent.

Line 4 – Weighted Average Risk Factor

This value is obtained from Section VI for total members (excluding ESRD and hospice). You must enter the projected non-DE# value. The DE# value is calculated based on the total and the non-DE# amounts. See the "Pricing Considerations" section of these instructions for more guidance.

If the value for DE# members equals zero, then the non-DE# risk score must equal the total risk score.

Line 5 – Conversion Factor

Calculated as (1.000 minus line 3) times line 4. This is an intermediate step in the BPT calculations.

Line 6 – Plan (or Regional) A/B Benchmark

Calculated as line 2 times line 5. The BPT finalization process will verify that this value must be greater than zero.

Line 7 – Plan A/B Bid

This value is obtained from Worksheet 4, then rounded to two decimals. The BPT finalization process will verify that this value must be greater than zero.

Line 8 – Standardized A/B Bid (@ 1.000)

Calculated as line 7 divided by line 5, then rounded to two decimals.

SECTION III – SAVINGS/BASIC MEMBER PREMIUM DEVELOPMENT

Line 1 – Savings

Calculated as the difference between the plan (or regional) A/B benchmark and the plan A/B bid, but not less than zero. This value is rounded to two decimals.

Line 2 – Rebate

Calculated as Section III, line 1 ("Savings") times Section V, line 3 ("Rebate %"). This value is rounded to two decimals.

Line 3 – Basic Member Premium

Calculated as the standardized A/B bid less the standardized A/B benchmark, but not less than zero. This value is rounded to two decimals.

The BPT will not finalize if there are any invalid values (such as "#N/A", "#DIV/0!", "#REF!", "#NAME?", etc.) in this field.

SECTION IV – STANDARDIZED A/B BENCHMARK – REGIONAL PLANS ONLY

This section calculates the standardized A/B benchmark for regional PPO plans.

Line 1 – Statutory Component for Region

The PMPM amount, defined by region, is pre-populated by CMS. The weighting is also pre-populated in the bid form by CMS.

Line 2 – Plan Bid Component

The plan bid component will be announced by CMS after the bids are submitted. It will likely be announced at the same time that the Part D national average is announced (typically in August).

Plan sponsors may input an estimated average regional bid amount in their initial June bid submission.

For bids that are submitted prior to the announcement of the RPPO averages, there are two options for completing this field: (1) leave the cell blank, in which case the plan's submitted standardized bid (Section II, line 8) is used as the plan bid component, or (2) input a reasonable estimate of the average RPPO bid for the region.

The RPPO announcement includes the weighted average MA RPPO bid for each region. Organizations will be instructed at the time of the announcement to submit revised RPPO MA BPTs with the applicable average bid amount entered in line 2. Regional employer bids ("800-series" bids) must also be resubmitted to reflect the RPPO average bids in line 2. Any changes in rebates due to the actual plan bid component must be re-allocated at the same time. Appendix E contains additional guidance regarding the rebate reallocation period.

Line 3 – Standardized A/B Benchmark

This line is calculated as the weighted average of lines 1 and 2 (if line 2 has a value entered). If line 2 does not have a value entered (that is, if the Plan sponsor has not entered an estimated value for a pre-announcement bid submission), the amount from Section II, line 8 is used in the calculation.

SECTION V – QUALITY RATING

This section captures quality rating information released by CMS. See the "Pricing Considerations" section of these instructions for more information.

Line 1 – Quality Bonus Rating (per CMS)

Enter the quality bonus rating (that is, "star rating") released by CMS for the contract. The rating is a numeric value from 1.0 through 5.0.

The value entered in the BPT will be validated upon upload. (That is, if the BPT value does not match the value released by CMS, the upload will be rejected.)

Line 2 – New/Low Indicator (per CMS)

Enter the new/low indicator released by CMS for the contract. The four valid options are as follows:

- New contract under existing parent org
- New contract under new parent org
- Low
- (Blank)

The text entered in the BPT will be validated upon upload. (That is, if the BPT text does not match the text released by CMS, the upload will be rejected.)

Line 3 – Rebate Percentage

The BPT computes the rebate percentage that is used in Section III, line 2.

SECTION VI – COUNTY-LEVEL DETAIL AND SERVICE AREA SUMMARY

This section contains detailed data by county and develops plan-specific county-level MA payment rates. For most plans, the only user inputs are the state-county codes (column b), projected member months (column e), and projected risk factors (column f) by county. Entries must reflect plan-specific enrollment projections for each county within the service area. Plans are permitted to project zero enrollment in a particular county in order to generate a county-level payment rate for that county.

As with all aspects of the projections for MA-PD plans, the enrollment and risk scores for the MA bid must be based on a population consistent with the corresponding Part D bid.

Payment rates for RPPOs may be developed using plan-provided geographic intra-service area rate (ISAR) factors on a case-by-case basis, as explained in the "Pricing Considerations" section of these instructions.

The BPT will not finalize if there are any invalid values (such as "#N/A", "#DIV/0!", "#REF!", "#NAME?", etc.) in Section VI.

Line 1 – Use of Plan-Provided ISAR Factors

Regional plans that wish to use ISAR factors to develop their county payment rates must enter "Yes". (Technical note: Do not enter "Y" in this field; enter the entire word "Yes".)

Line 2 – Total or Weighted Average for the Service Area

The county-level data are summarized in this line, weighted by projected member months.

Line 3 – County-Level Detail

✓ **Column b – State-County Code**

Enter the Social Security Administration (SSA) state-county codes that define the MA service area, in accordance with the following:

- Each state-county code must be entered as a text input (that is, must include a preceding apostrophe) and must include all leading zeroes (for example, '01000).

This field is formatted as the "General" format in Excel, in order to support the functionality to link spreadsheets. Therefore, county codes must be entered as text (that is, using a preceding apostrophe) and must include any leading zeros.

- If the service area has more than one county, do not leave any blank rows between the first and last state-county code entered. Also, do not leave blank rows before the first county code entered.
- Do not enter the same state-county code more than once.
- Do not insert any additional rows in the worksheet.
- Do not input the out-of-area (OOA) county, "99999". OOA enrollees are not represented in the benchmark calculation.
- The county codes entered in the BPT must match the service area defined in HPMS by the MA organization. Any service area discrepancies between the BPT and HPMS may result in delays during bid review and could affect the approval timeline of the bid.

Technical note: In the "finalized" MA BPT file, the county-level section will be sorted in a descending order, based on the county codes entered in column b. See the BPT technical instructions for further information.

✓ **Column c – State**

The BPT will display the applicable state name based on the corresponding code entered in column b. No user entry is required.

✓ **Column d – County Name**

The BPT will display the applicable county name based on the corresponding code entered in column b. No user entry is required.

✓ **Column e – Projected Member Months**

Enter the projected contract year member months for each county in the service area. The projected member months must include both aged and disabled members, and DE# and non-DE# members, but exclude ESRD and hospice members.

See the "Pricing Considerations" section of these instructions for more guidance.

Technical note: The data will display as whole values but can be entered with decimal places.

If member months are entered in a particular row of column e, then a corresponding county code and a risk score must be entered in columns b and f, respectively.

✓ **Column f – Projected Risk Factors**

Enter the risk factors for the projected non-ESRD non-hospice membership by county.

If a risk score is entered in a particular row of column f, then a corresponding county code must be entered in column b.

✓ **Column g – Plan-Provided ISAR Factors**

If the Plan sponsor has support for plan-specific ISAR factors for a regional PPO, then—

- Enter "Yes" in line 1, in response to the question "Use of plan-provided ISAR?" (Technical note: Do not enter "Y" in this field; enter the entire word "Yes".)
- Enter the plan-provided ISAR factors in column g of the county-level section. Factors can be in the form of either PMPM values or a relative scale.

✓ **Column h – MA Risk Ratebook: Unadjusted**

The BPT will display the applicable published ratebook risk rates for the contract period. If enrollee type is "A/B," the amounts shown are the total of Part A and Part B. If enrollee type is "Part B-Only", the amount shown is the Part B rate.

✓ **Column i – MA Risk Ratebook: Risk-Adjusted**

The BPT will calculate the risk-adjusted rates based on the rates in column h and the risk scores entered in column f.

✓ **Column j – ISAR Scale**

The BPT will calculate the ISAR scale based on either the plan-provided ISAR factors in column g (if provided) or the ratebook rates in column h.

✓ **Column k – ISAR-Adjusted Bid**

The BPT will calculate the ISAR-adjusted bid based on the ISAR scale in column j and the standardized A/B bid in Section II. Note that the payment rates represent coverage for Medicare Part A and Part B (except for Part B-only plans). The values will then be separated into Part A and Part B payment rates in columns l and m.

✓ **Columns l through m – Risk Payment Rates**

These columns are calculated based on the ISAR-adjusted bid in column k and the risk ratebook proportions for Part A and Part B.

SECTION VII – OTHER MEDICARE INFORMATION

This section contains county-level Medicare information used in the bid form and is populated based on the county codes input in column b and the projected member months entered in column e.

The BPT will not finalize if there are any invalid values (such as "#N/A", "#DIV/0!", "#REF!", "#NAME?", etc.) in Section VII.

Columns n through p – Original Medicare Cost-Sharing Proportional Factors

These columns are populated based on the enrollment projections and are used in column k of Worksheet 4, Section IIA.

Columns q through s – FFS Costs Used to Weight Original Medicare Cost Sharing

These columns are populated based on the enrollment projections and are used in the weighted averages (row 36) of columns n through p.

Columns t through u – Metropolitan Statistical Area (MSA)

These columns are populated based on the enrollment projections. The names shown are based on metropolitan and micropolitan statistical areas, as defined by the Office of Management and

Budget. Though this information is not directly used in the BPT calculations, it is used by CMS during bid reviews.

MA WORKSHEET 6 – MA BID SUMMARY

Worksheet 6 summarizes the results of the calculations of the bid form. In addition, some user inputs are required, as described below.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – OTHER INFORMATION

Section A – Part B Information

See the "Pricing Considerations" section for further information regarding allocating rebates to buy down the Part B premium.

Line 1 – Maximum Part B Premium Buydown Amount, per CMS

This value is pre-populated by CMS at the time that the bid form is released.

Section B – Rebate Allocation for Part B Premium

Line 1 – PMPM Rebate Allocation for Part B Premium

Enter the PMPM amount of rebates to reduce the Part B premium.

Line 2 – Rounded Part B Rebate Allocation

The PMPM amount entered in line 1 is rounded to one decimal (that is, the nearest dime) to comply with withhold system requirements.

Section C – Rebate Allocations

Line 1 – Reduce A/B Cost Sharing

Enter the PMPM amount of rebates to reduce A/B cost sharing.

Line 2 – Other A/B Mandatory Supplemental Benefits

Enter the PMPM amount of rebates to apply toward other A/B mandatory supplemental benefits.

SECTION III – PLAN A/B BID SUMMARY

Section III summarizes the bid pricing tool information in three sections.

- Section A is an overview of the plan A/B bid and the costs of A/B mandatory supplemental benefits, and it also contains some benchmark and risk score information from Worksheet 5.
- Section B contains the MA rebate allocation.

- Section C develops the MA premium and requires the input of the Part D premium information. Consistent with previous worksheets, any optional supplemental benefits/premiums are to be excluded.

Section A – Overview

This section summarizes information entered on previous worksheets.

Line 1 – Net Medical Cost

These amounts are obtained from Worksheet 4.

Line 2 – Non-Benefit Expenses

These amounts are obtained from Worksheet 4.

Line 3 – Gain/Loss Margin

These amounts reflect the estimated net gain/loss for the plan, including the amount of risk margin desired. These amounts are obtained from Worksheet 4.

Line 4 – Total Revenue Requirement

The sum of lines 1 through 3. These amounts are the required revenue at the plan's non-ESRD risk factor and are calculated prior to any rebate allocation.

Line 5 – Standardized A/B Benchmark

This amount is obtained from Worksheet 5.

Line 6 – Plan A/B Benchmark (or Regional A/B Benchmark for RPPO Plans)

This amount is obtained from Worksheet 5.

Line 7 – Risk Factor

This amount is obtained from Worksheet 5.

Line 8 – Conversion Factor

This amount is obtained from Worksheet 5.

Section B – MA Rebate Allocation

Plan sponsors may choose which of the following category, or categories, in which to allocate rebates.

- Reduce A/B cost sharing.
- Other A/B mandatory supplemental benefits.
- Part B premium buydown.
- Part D basic premium buydown.
- Part D supplemental premium buydown.

See Appendix E for information regarding the reallocation of rebates (permitted for certain plans) after the publication of the Part D and MA regional benchmarks.

Line 1 – MA Rebate

This amount is obtained from Worksheet 5.

The BPT will not finalize if there are any invalid values (such as "#N/A", "#DIV/0!", "#REF!", "#NAME?", etc.) in this field.

Lines 2 through 6 – Rebate Allocations by Category

The fourth column displays the portion of the total MA rebate that is allocated to each of the A/B rebate options. Note that the rebate allocations are actually entered in separate sections of this worksheet, to ensure that the rebate allocations are rounded to comply with withhold system requirements.

The first three columns distribute the allocated rebate among medical expenses, non-benefit expenses, and gain/loss in the same proportion as used in Worksheet 4. The fifth column contains the maximum value that applies to each rebate category. See the "Pricing Considerations" section of these instructions for more information on rebate allocation.

The BPT will not finalize if there are any invalid values (such as "#N/A", "#DIV/0!", "#REF!", "#NAME?", etc.) in these fields.

Line 7 – Total Rebate Allocated

The sum of lines 2 through 6. This amount must equal the amount in line 1.

If there are any "unallocated" rebates shown, including pennies, these amounts must be distributed among the categories available. The BPT will not finalize if there are any invalid values (such as "#N/A", "#DIV/0!", "#REF!", "#NAME?", etc.) in this field.

Section C – Development of Estimated Plan Premium

Line 1 – A/B Mandatory Supplemental Revenue Requirements

This amount is obtained from Section IIIA.

Line 2 – Less Rebate Allocations

These amounts are obtained from Section IIIB, lines 2 and 3.

Line 3 – A/B Mandatory Supplemental Premium

The sum of lines 1 and 2.

Line 4 – Basic MA Premium

This amount is obtained from Worksheet 5.

Line 5 – Total MA Premium (excluding Optional Supplemental)

The sum of lines 3 and 4.

Line 6 – Rounded MA Premium (excluding Optional Supplemental)

The total MA premium from line 5 is rounded to one decimal (that is, the nearest dime) to comply with withhold system requirements. Value must be greater than or equal to zero.

The BPT will not finalize if there are any invalid values (such as "#N/A", "#DIV/0!", "#REF!", "#NAME?", etc.) in this field.

Line 7 – Part D Basic Premium

- ✓ **Line 7a – Prior to Rebates**

  Enter the Part D basic premium prior to rebates after rounding (found on the separate Part D bid form). This amount must equal the amount on the Part D BPT (that is, the amount prior to application of any MA rebates). Note: The Part D basic premium prior to rebates must be entered in the MA BPT, even if no MA rebates are allocated to buy down the Part D basic premium. This field is not applicable to MA-only plans and EGWP plans.

- ✓ **Lines 7b and 7c – A/B Rebates Allocated to the Part D Basic Premium**

  Enter the rebates that the Plan sponsor wishes to allocate to the Part D basic premium. The Part D rebate allocation must be rounded to one decimal. If this is not done, then the bid form will round these rebates to one decimal (in line 7c), to comply with withhold system requirements. This field is not applicable to MA-only plans and EGWP plans.

- ✓ **Line 7d – Part D Basic Premium**

  The estimated Part D basic premium net of rebates is calculated automatically as line 7a minus line 7c.

  The Part D basic premium in the MA BPT is an estimate when the bid is initially submitted in June. The actual plan premium will be calculated by CMS, outside the BPT, when the Part D national average monthly bid amount is determined (typically in August).

  Note that the Part D basic premium prior to rebates can be a negative number.

  This field is not applicable to MA-only plans and EGWP plans, and it must be equal to zero.

  If the plan intention for the target premium (cell R47) equals "Low-Income Premium Subsidy Amount" and the plan enters Part D basic rebates (cell R36) greater than zero, then the Part D basic premium after rebates (cell R37) must be greater than zero.

Line 8 – Part D Supplemental Premium

- ✓ **Line 8a – Prior to Rebates**

  Enter the Part D supplemental premium prior to rebates (found on the separate Part D bid form) after rounding. This amount must equal the amount on the Part D BPT (that is, the amount prior to application of any MA rebates). Note: The Part D supplemental premium prior to rebates must be entered in the MA BPT, even if no MA rebates are allocated to buy down the Part D supplemental premium. This field is not applicable to MA-only plans and EGWP plans.

  Note that if the Part D basic premium is negative, then the Part D supplemental premium must offset the negative amount. That is, the sum of the Part D basic and supplemental premiums must be greater than or equal to zero.

✓ **Lines 8b and 8c – A/B Rebates Allocated to the Part D Supplemental Premium**

Enter the rebates that the Plan sponsor wishes to allocate to the Part D supplemental premium. The Part D rebate allocation must be rounded to one decimal. If this is not done, then the bid form will round these rebates to one decimal (in line 8c), to comply with withhold system requirements. This field is not applicable to MA-only plans and EGWP plans.

✓ **Line 8d – Part D Supplemental Premium**

Calculates the Part D supplemental premium net of rebates. Line 8d equals line 8a minus line 8c. The value must be greater than or equal to zero. This field is not applicable to MA-only plans and EGWP plans, and it must be equal to zero in these cases.

The BPT will not finalize if there are any invalid values (such as "#N/A", "#DIV/0!", "#REF!", "#NAME?", etc.) in this field.

Line 9 – Total Estimated Plan Premium

The sum of the rounded MA, Part D basic, and Part D supplemental premiums after rebates. This amount excludes any optional supplemental MA premiums, which are calculated on Worksheet 7. The value must be greater than or equal to zero.

The BPT will not finalize if there are any invalid values (such as "#N/A", "#DIV/0!", "#REF!", "#NAME?", etc.) in this field.

Line 10 – Plan Intention for Target Part D Basic Premium

For MA-PD plans, this field contains a drop-down menu with two options: "Premium amount displayed in line 7d" or "Low-Income Premium Subsidy Amount". MA-PD Plan sponsors must choose one of these two options for the target Part D basic premium in the initial June bid submission and cannot change the chosen target in a subsequent resubmission. CMS will consider only the option chosen in June as the plan's intention.

For MA-only plans and EGWPs, the target Part D basic premium is not applicable.

See the "Pricing Considerations" section of these instructions for more information on the target Part D basic premium.

SECTION IV – CONTACT INFORMATION AND DATE PREPARED

Plan sponsors must identify three persons as MA plan bid contact, MA certifying actuary, and additional MA BPT actuarial contact. The MA certifying actuary and additional MA BPT actuarial contact must be readily available and authorized to discuss the development of the pricing of the bid.

In this section, enter the name, phone number, and e-mail information for all three contacts; in addition, credentials are a required input for the certifying actuary. For the phone number, enter all ten digits consecutively without parentheses or dashes. Do not leave any part of this section blank.

Section IV also contains a field labeled "Date Prepared". This field must contain the date that the BPT was prepared. If the BPT is revised and resubmitted during the bid review process, then this field must be updated accordingly.

SECTION V – WORKING MODEL TEXT BOX

This section contains multiple cells that may be used by bid preparers to enter internal notes—for example, to facilitate communication between BPT and PBP preparers or to track internal version schemes.

Section V will be deleted from the finalized file and therefore will not be uploaded to HPMS. Bid preparers must not enter information in this section meant to be communicated to CMS or to CMS reviewers, as CMS will not have access to it. Section V will not be deleted from the working file or from the backup file during finalization.

MA WORKSHEET 7 – OPTIONAL SUPPLEMENTAL BENEFITS

Worksheet 7 contains the actuarial pricing elements for any optional supplemental benefit (OSB) packages to be offered during the contract year, up to a maximum of five.

The PBP packages must be entered in the same order as they are entered in the PBP.

For each of the five packages, the worksheet contains 20 category lines. If additional category lines are needed, then provide a supporting exhibit that shows all of the benefit category details, and include a summary of those category lines on this worksheet. Do not insert any additional rows into the form.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – OPTIONAL SUPPLEMENTAL PACKAGES

Column b – Package ID

Displays the identification (ID) number to signify which package of optional supplemental benefits is being priced. The number "1" is used to identify the first package. Sequential numbers (that is, 2, 3) identify additional packages of optional supplemental benefits. The package IDs must correspond to the packages enumerated and described in the PBP.

Column c – Service Category

On the first line for each package, enter a description of the OSB package. This description must match the description entered in the PBP for each package. Examples: "Enhanced Dental", "Gold Package", etc. The description field must not be left blank when there is an optional supplemental package entered.

On each subsequent line, enter the service category. Valid entries are those consistent with the categories included on Worksheet 1:

- Inpatient Facility
- Skilled Nursing Facility
- Home Health
- Ambulance
- DME/Prosthetics/Supplies
- OP Facility – Emergency
- OP Facility – Surgery
- OP Facility – Other
- Professional
- Part B Rx
- Other Medicare Part B
- Transportation (Non-covered)
- Dental (Non-covered)

- Vision (Non-covered)
- Hearing (Non-covered)
- Health & Education (Non-covered)
- Other Non-covered

Column d – Benefit Category/Pricing Component

Enter a description of the benefit category/pricing component.

Column e – Allowed Medical Expense: Utilization Type

Enter the appropriate measurement unit from the list used for column e of Worksheet 2.

Column f – Allowed Medical Expense: Annual Utilization/1,000

Enter the projected contract year annual utilization per thousand enrollees for allowed medical expenses for each benefit category.

Column g – Allowed Medical Expense: Average Cost

Enter the projected contract year average annual cost for allowed medical expenses for each benefit category.

Column h – Allowed Medical Expense: PMPM

Column h is calculated automatically using the utilization reported in column f and the average cost information reported in column g.

Column i – Enrollee Cost Sharing: Measurement Unit Code

Enter the appropriate cost-sharing measurement unit using the codes provided for column e of Worksheet 3.

Column j – Enrollee Cost Sharing: Utilization/1000 or PMPM

Enter the projected contract year utilization per thousand enrollees or the PMPM value in the case of coinsurance.

Column k – Enrollee Cost Sharing: Average Cost Sharing

Enter the projected contract year average per-service cost-sharing amount or coinsurance percentage.

Column l – Enrollee Cost Sharing: PMPM

Column l is calculated automatically using the utilization (or PMPM) reported in column j and the average cost (or coinsurance percentage) reported in column k.

Column m – Net PMPM Value

Column m is calculated automatically as the allowed PMPM (column h) minus the cost sharing PMPM (column l).

Column n – Non-Benefit Expense

Enter the total projected contract year non-benefit expense for each OSB package offered.

Column o – Gain/Loss Margin

Enter the total projected contract year gain/loss margin for each OSB package offered.

Column p – Premium

The sum of columns m (medical expenses), n (non-benefit expenses), and o (gain/loss margin). The premiums are automatically rounded to one decimal to comply with premium withhold system requirements. Premium values must be greater than zero if an OSB package is offered and must be equal to zero if an OSB package is not offered.

Column q – Projected Member Months

Enter the total projected contract year member months for each OSB package offered.

SECTION III – COMMENTS

Enter any comments needed to describe the OSB packages.

IV. APPENDICES

APPENDIX A – ACTUARIAL CERTIFICATION

CMS requires an actuarial certification to accompany every bid submitted to HPMS. A qualified actuary who is a member of the American Academy of Actuaries (MAAA) must complete the certification. The objective of obtaining an actuarial certification is to place greater responsibility on the actuary's professional judgment and to hold him/her accountable for the reasonableness of the assumptions and projections.

Actuarial Standards of Practice and Other Considerations

In the actuarial certification, the actuary must certify that the actuarial work supporting the bid conforms to the current Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board. While other ASOPs apply, particular emphasis is placed on the following:

- ASOP No. 5, *Incurred Health and Disability Claims*.
- ASOP No. 8, *Regulatory Filings for Health Plan Entities*.
- ASOP No. 23, *Data Quality*.
- ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*.
- ASOP No. 41, *Actuarial Communications*.

The certifying actuary must also certify that the actuarial work supporting the bid complies with applicable laws, rules, CY2013 bid instructions, and current CMS guidance. In addition, he/she must consider whether the actuarial work supporting the bid is consistent and reasonable with respect to the plan benefit package and the organization's current business plan.

Certification Module

The certification module contains the following features:

- Standardized required language. (The required elements are described in a subsequent section of this appendix.)
- The ability to append free-form text language to the required standardized language.
- A summary of key information from the submitted bids.
- Links to additional information regarding the bid package such as the PBP, BPT, and supporting documentation.
- The ability to certify multiple bids/contracts.
- The ability to print and save the submitted certification.

An initial actuarial certification must be submitted via the HPMS certification module in June. The actuary must also certify the final bid (that is, pending CMS approval) via the certification module in August following the CMS publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional benchmarks. Actuaries are not required to certify every intermittent resubmission throughout the bid review process, but they may do so if they wish.

Note that in the event that the PBP changes after the "final" bid is certified, the bid that is uploaded into HPMS with the revised PBP must be recertified whether or not the BPT changes.

As was instructed in previous contract years, material changes to the certification language (after the initial June certification submission) are not allowed without prior written permission from the CMS Office of the Actuary.

Plan sponsors may have multiple actuaries assigned to one contract to perform the certifications. For example, a consulting actuary may certify the Part D portion of a bid, while an internal plan staff actuary may certify the MA portion of the bid. Also, one actuary may certify plan Hxxxx-001, while a different actuary may certify plan Hxxxx-002. The instructions contained in this appendix must be followed by all actuaries who will be certifying CY2013 bids.

If a certification is not submitted via the HPMS certification module, the bid will not be considered for CMS review and approval.

Every MA BPT requires a certification. Likewise, every PD BPT requires a certification. Since Part D BPTs are not submitted for "800-series" EGWP employer bids, a Part D actuarial certification is not required. However, a certification is still required for the MA portion of "800-series" employer bids.

Additional information regarding the actuarial certification process (including technical instructions for completing the HPMS certification module) will be included in the initial actuarial certification deadline memorandum issued in June 2012.

Required Certification Elements

The certification module contains the following information, as part of the standardized language:

- The certifying actuary's name/user ID and the date, "stamped" when the certification is submitted.
- Attestation that the actuary submitting the certification is a member of the American Academy of Actuaries (MAAA). As such, the actuary is familiar with the requirements for preparing Medicare Advantage and Prescription Drug bid submissions and meets the Academy's qualification standards for doing so.
- The specific contract, Plan ID, and segment ID of the bid associated with the certification.
- The contract year of the bid contained in the certification.
- Indication of whether the certification applies to the Medicare Advantage bid, the Part D bid, or both.
- Attestation that the certification complies with the applicable laws,[1] rules,[2] CY2013 bid instructions, and current CMS guidance.

[1] Social Security Act sections 1851 through 1859; and Social Security Act sections 1860D-1 through 1860D-42.

[2] 42 CFR Parts 400, 403, 411, 417, 422, and 423.

- Attestation that, in accordance with federal law, the bid is based on the "average revenue requirements in the payment area for a Medicare Advantage/Prescription Drug enrollee with a national average risk profile."
- Attestation that the data and assumptions used in the development of the bid are reasonable for the plan's benefit package (PBP).
- Attestation that the data and assumptions used in the development of the bid are consistent with the organization's current business plan.
- Attestation that the bid was prepared in compliance with the current standards of practice, as promulgated by the Actuarial Standards Board of the American Academy of Actuaries, and that the bid complies with the appropriate ASOPs.
- A statement that, in compliance with ASOP No. 23, any data and assumptions provided by reliances were reviewed for reasonableness and consistency and that supporting documentation for the reliance on information provided by others is uploaded with the bid.

Please refer to ASOP No. 23, *Data Quality*, and ASOP No. 41, *Actuarial Communications*, for additional details regarding reliances.

If you have any questions regarding the CY2013 certification instructions, please contact the CMS Office of the Actuary at actuarial-bids@cms.hhs.gov.

Certification Module Access

Detailed instructions regarding how to apply for access to the CY2013 certification module were released via an HPMS memorandum dated March 3, 2012.

APPENDIX B – SUPPORTING DOCUMENTATION

GENERAL

In addition to the BPT and actuarial certification, Plan sponsors must provide CMS with supporting documentation for every bid, as described in these instructions.

Unless otherwise noted, Plan sponsors must upload all required supporting documentation at the time of the initial June bid submission. Additional supporting documentation, if requested, must be made available to CMS reviewers within 48 hours, as required by these instructions. Plan sponsors must upload supporting documentation consistent with the final certified bid.

Supporting documentation requirements apply regardless of the source of the assumption, whether it was developed by the actuary, the Plan sponsor, or a third party. If the actuary relied upon others for certain bid data and/or assumptions, those individuals are subject to the same documentation requirements. The actuary must be prepared to produce all substantiation pertaining to the bid, even if it was prepared by others or is based on a reliance.

In preparing supporting documentation, the actuary must consider ASOP No. 41, *Actuarial Communications.* In accordance with Section 3.2, "Actuarial Report," the materials provided must be written "with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work."

All data submitted as part of the bid process are subject to review and audit by CMS or by any person or organization that CMS designates. Certifying actuaries must be available to respond to inquiries from CMS reviewers regarding the submitted bids.

Supporting documentation must be easily understood by CMS reviewers and must include the following:

- The rationale for the assumption, including quantitative support and details, rather than just narrative descriptions of assumptions.
- Plan-specific variations in addition to the overall pricing assumption or methodology.
- Values that match entries in the current BPT and tie to the PBP.
- Excel spreadsheets with working formulas, rather than pdf files.

Supporting documentation must be clearly labeled and include the following information:

- The bid ID. At a minimum, the contract number and organization name must appear on the first page. Specific plan numbers must be included where appropriate, such as on the first page, in a separate chart, or as an attachment.
- A reference to MA, Part D, or both.
- A hard-coded date.
- Contract/Plan number and topic in the beginning of the file name.

Acceptable forms of supporting documentation include, but are not limited to, the following items:

- Meeting minutes from discussions related to bid development.
- E-mail correspondence related to bid development.

- A complete description of data sources—for example, a report's official name/title, file name, date obtained, source file, etc.
- Intermediate calculations showing each step taken to calculate an assumption.
- A summary of contractual terms of administrative services agreements.
- A business plan.

Supporting documentation that is not acceptable or that may result in a request for additional information includes, but is not limited to, the following items:

- Materials that can be accessed only through a secure server link that requires a password.
- A reference to the supporting documentation for another plan, such as "the same as for plan Hxxxx-xxx," and not the documentation itself. The supporting documentation for a plan must be self-contained.
- General descriptions of pricing that do not include plan-specific information.
- A statement that the source of a pricing assumption is "professional judgment" with no additional explanation of the data points underlying the assumptions—for example, supporting factors, studies, or public information.
- "Living worksheets" that are overwritten with current data. Supporting documentation must include the version of the worksheet that was used in bid preparation.
- Information obtained after the bids are submitted.
- A statement that a pricing assumption or methodology is assumed acceptable based on its inclusion in a bid that was approved by CMS in a prior contract year. Data, assumptions, methodologies, and projections must be determined to be reasonable and appropriate for the current bid, independent of prior bid filings.

SUBMITTING SUPPORTING DOCUMENTATION

Supporting materials must be in electronic format (Microsoft Excel, Microsoft Word, or Adobe Acrobat) and must be uploaded to HPMS. CMS will not accept paper copies of supporting documentation. Note that multiple substantiation files can be submitted to HPMS at one time by using "zip" files, which compress multiple files into one (.zip file extension). Also, one file can be uploaded to multiple plans in HPMS by using the CTRL key when plans are selected. However, documentation must not be uploaded to plans to which it does not pertain. It is not acceptable to upload to multiple plans materials specific to a Part D plan, MA plan, or certain contract ID.

Cover Sheet

To expedite the bid review process, Plan sponsors must upload a cover sheet that lists all of the supporting documentation that is uploaded or provided on the bid form. The filename must include the phrase "cover sheet." A cover sheet is required for each upload of substantiation.

The cover sheet must include detailed information for each support item—such as the filename and the location within the file, if applicable—and must clearly identify the bid IDs and whether the substantiation is related to MA, Part D, or both.

Note that some documentation requirements apply to every bid (for example, every bid contains a risk score assumption), while other documentation requirements apply only to bids

that contain certain assumptions (for example, manual rate documentation applies only if a bid's projection is based on manual rates). For documentation categories that apply to a subset of bids that contain a specified assumption, the cover sheet must not refer to a "range" of bid IDs (such as "plans 001 – 030" or "all plans under contract Hxxxx"). For these items, the cover sheet must contain the exact bid IDs (contract/plan/segment) to which the documentation applies.

For subsequent substantiation uploads, the cover sheet must summarize the additional documents uploaded at that time (that is, the cover sheet must not be maintained as a cumulative list). The subsequent cover sheets must also contain the exact bid IDs rather than a "range" of bid IDs.

Sample check lists and cover sheets for the initial June bid submission, and for subsequent substantiation uploads, are provided at the end of this appendix.

Timing

Plan sponsors and certifying actuaries must prepare all supporting documentation and upload required documentation into HPMS at the time of the initial June bid submission. These items are described in the "Initial June Bid Submission" section below.

Moreover, CMS recommends that other supporting documentation materials be uploaded with the initial June bid submission, though this is not required. See the "Upon Request by CMS Reviewers" section of this appendix for more information. However, these materials must be prepared at that time in order to be readily available to CMS reviewers upon request. When additional substantiation is requested by CMS reviewers, it must be provided within 48 hours and uploaded into HPMS prior to bid approval. Plan sponsors must also upload additional substantiation provided in e-mail correspondence and supporting documentation consistent with the final certified bid.

Initial June Bid Submission

The following documentation requirements apply to all bids (as all bids contain these assumptions):

- A cover sheet outlining the documentation files, as described above.
- A product narrative that offers relevant information about plan design, the product positioning in the market (such as high/low), enrollment shifts, service area changes, type of coverage, contractual arrangements, marketing approach, and any other pertinent information that would help expedite the bid review. For dual-eligible SNPs, include a statement indicating how the plan conforms to state and territorial Medicaid regulations for benefits, cost sharing, care management, and margins.
- Support for the credibility assumptions (Worksheet 2), including—
    - A statement of the credibility approach used—for example, the CMS guideline or the CMS override.
    - A description of the credibility methodology used if it varies from the CMS guideline or the CMS override.
    - The method for blending differences between the credibility for utilization and that for unit cost into a composite PMPM credibility factor.
    - Justification for any variation in the credibility approach by line of business.

    - An explanation for a zero credibility percentage for a service category with credible data.
- A detailed description of the process used for adjusting cost sharing due to maximum OOP limits (Worksheet 3).
- A mapping of cost-sharing information from categories used in pricing to the BPT service categories (Worksheet 3).
- Support for non-benefit expense assumptions. The required elements include—
    - A reconciliation of the base period non-benefit expenses reported in the BPT and auditable material such as corporate financials and plan-level operational data (Worksheet 1).
    - A description of the expenses included in each non-benefit expense category in the BPT. (Worksheet 4)
    - Detailed support for the development of projected non-benefit expenses (Worksheet 4). The required elements include—
        - A description of the methodology used to develop projected non-benefit expenses.
        - A description of the data source and its relationship to the base period non-benefit expenses reported in the BPT.
        - A demonstration of the development of each line item using relevant data, assumptions, contracts, financial information, business plans, and other projections.
- Justification of the gain/loss margin (Worksheet 4). The required elements include—
    - Support for overall margin levels including—
        - A description of the methodology used to develop the gain/loss margin assumption, the level at which the overall margins are determined, demonstration of year-by-year consistency of projected margins, and supporting data.
        - A demonstration of year-by-year consistency between the expected overall margin level for general enrollment plans and I/C SNPs combined (or for other plan groupings, if applicable) and the Plan sponsor's corporate margin requirement over time (for example, 3 to 5 years), including any change in the Plan sponsor's corporate margin requirement in the prior 2 years.
        - For MA-PD plans, a description of the approach for setting the Part D margin in relation to the MA margin.
        - A detailed description of unique situations in which the margin level for DE-SNPs is outside of the stated range of the margin level for general enrollment plans and I/C SNPs combined, including the rationale for the exception and evidence of advance approval by CMS, if applicable.
    - Support for bids with negative margins, including one of the following items:
        - For a new plan, or a plan with a zero or positive projected gain/loss margin for the prior contract year, a year-by-year numeric business plan that demonstrates profitability within a few years.
        - For a plan with a negative projected gain/loss margin for the prior contract year, a numerical comparison of the gain/loss margin to the margin in the original business plan. The required elements include—

        - Details and sources of deviation from the original business plan.
        - An explanation and demonstration as to how the targeted margin in the original business plan will be met, if the plan is progressing towards a positive margin less rapidly than projected in the original business plan.
        - A copy of the original business plan uploaded to HPMS in a separate file.
      - A description of the product pairing, which includes the gain/loss margin for each plan and shows that the plans have—
        - Identical service areas,
        - The same plan type, and
        - A positive combined gain/loss margin.
    - Justification for bids with relatively large projected overall gains/losses including an explanation of how the PBP offers benefit value in relation to the margin level.
- Detailed support for the development of projected risk scores (Worksheet 5). The required elements include—
    - A detailed description, and corresponding numerical demonstration, of the methodology used to develop projected CY2013 MA risk scores.
    - A description of the source data for the development of the projected CY2013 MA risk scores.
    - A description of all projection factors and the basis for the factors.
    - A demonstration that the method used is consistent with the preferred development approach in these instructions.
    - A statement about the consistency between the development of the projected risk scores for the plan population and the development of projected medical expenses, if the plan pricing is based on manual rates.

  A sample summary of the development of the projected risk scores is provided at the end of Appendix B.

The following documentation requirements apply to all bids that contain the assumptions specified below:

- Detailed support for the development of base period experience (Worksheet 1). This documentation, which is based on regulatory authority for the review of materials that pertain to any aspect of services provided, is also required in cases in which medical services are provided under a capitated arrangement. The required elements include—
    - A description of the allocation of allowed costs by service category when the allocation method is not based on plan experience data (Worksheet 1).
    - Information regarding the base period member months, if for some reason more than four plans constitute the base period data (see Worksheet 1, Section II, line 5).
    - Reconciliation of base period experience with company financial data (Worksheet 1). The data are to be reported on an incurred, rather than an accounting or GAAP, basis, including both claims paid and unloaded claim reserves. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis.

- Detailed qualitative and quantitative support for the development of each projection factor (Worksheet 1). The required elements include—
    - A description of the source data, including the data's relevance to the MA plan.
    - A summary of the Plan sponsor's historical trends including—
        - The percentage trends.
        - A description of the methodology used to analyze the data.
        - The numeric calculations.
    - Any applicable adjustments to the source data, such as considerations for—
        - Plan sponsor's experience.
        - Industry and/or internal studies.
        - Benefit design analysis.
- Support for the pricing, including utilization and unit cost, of incentive programs for preventive services (Worksheets 1 and 2, line q).
- Support for claim costs for hospice enrollees for mandatory supplemental benefits when these costs are included in the projected allowed cost PMPM.
- Detailed support for the manual rate development (Worksheet 2), including a description/illustration of the underlying data source(s) and data/methodology used in the development of the manual rates, if manual rates are used. The required elements include—
    - A description of the source data, including the data's relevance to the MA plan and the precise name of any published tables used.
    - Credibility standards applied to the data and corresponding adjustments, if applicable.
    - Consideration of any adjustments made for annual volatility of the source data.
    - Any applicable adjustments to the source data, such as—
        - Approach and factors applied to account for incomplete claim run-out and/or expenditures that are not reflected in the source data.
        - Addition of Medicare-covered benefits not reflected in the source data.
        - Exclusion of non-covered benefits reflected in the source data.
        - Techniques and factors used to reflect differences between the underlying population and that expected of the MA plan.
        - Techniques and factors used to adjust for differences in health care delivery system and plan design of the source data as compared to the MA plan.
        - Methodology and data used to gross up reimbursements to an allowed-cost basis.
    - Data and methodology used to project the data from base period to CY2013.
    - A description of the source of data for the development of corresponding CMS-HCC model risk scores and how that source compares to the risk profiles of the population underlying the manual rate source data.
    - The reasonableness of allowed costs and projection factors for costs based on capitated payments to related parties.
    - The allocation of projected allowed costs by service categories.
    - All other applicable factors and/or adjustments.

- Support for non-DE# projected allowed costs (Worksheet 2).
- A mapping of PBP benefit categories and BPT pricing categories for any deviations from the suggested mappings in Appendix F (Worksheet 2).
- An explanation for a zero cost of a benefit that is included in the PBP.
- The rationale for including in non-benefit expenses the cost of a benefit that is included the PBP.
- Support, at the benefit level, for non-covered services (Worksheet 2, lines l through q, column o), if any, including a breakdown of the PMPM value shown in the BPT. For example, a $4.00 PMPM in column o of row p, "Health and Education," is to be shown in the supporting documentation as $1.50 PMPM for a smoking cessation program and $2.50 PMPM for nutritional counseling. (Detailed support for the pricing of each additional benefit is available upon request.)
- Disclosure of related-party medical and service agreements (Worksheets 1and 4).
    - A Plan sponsor in a related-party agreement with an organization and prepares the BPT in a manner that does not recognize the independence of the subcontracted related party must provide the following:
        - The identity of the related-party organization.
        - A description of the business arrangement and services provided.
        - The financial terms.
        - A point of contact at the related party (when the sponsor is requesting that CMS enter into a separate discussion with a subcontracted related party).
    - A Plan sponsor in a related-party agreement with an organization that is providing services to unrelated parties and chooses to demonstrate that the terms and fees associated with their agreement are comparable to those obtained by unrelated parties of the organization must provide the following:
        - The identity of the related-party organization.
        - A description of the business arrangement and services provided.
        - The financial terms.
        - A point of contact at the related party (when the sponsor is requesting that CMS enter into a separate discussion with a subcontracted related party).
        - A written summary outlining the terms of actual contracts between the subcontractor and the comparable, unrelated parties for similar services. The support must demonstrate that the financial arrangements between related parties are not significantly different from those that would have been achieved by the Plan sponsor in the absence of the related-party relationships.
- Support for the development of the contract year ESRD subsidy (Worksheet 4). This required documentation includes the following:
    - Base period (for example, 2011) revenues and medical expenditures for Medicare-covered benefits provided to enrollees in ESRD status.
    - The source for, and the development process of, any manual rates used.
    - Relevant base-to-contract year trend factors.
    - A short narrative on the credibility approach applied to the ESRD experience.

- Support for zero projected DE# member months when there are DE# members in the base period (Worksheet 5).
- Support for the development of plan-provided ISAR factors (Worksheet 5), if used. (This requirement applies to RPPOs only.) A description of the methodology and data source(s) used to calculate the ISAR scale(s) must be included. The factors must reflect the requirements for medical expense, non-benefit expense, and gain/loss margin. Additionally, the support must illustrate the county-level medical costs (such as unit costs and/or utilization) and retention (that is, non-benefit expense and gain/loss margin) that were assumed in the development of the factors.
- Contract-level optional supplemental experience for CY2011, including enrollment, earned premiums, and incurred benefits (Worksheet 7).
- Support for the benefit, non-benefit expense, and gain/loss margin for specific OSB packages (Worksheet 7).
- In accordance with Appendix D, support for actuarial swaps/equivalence customization allowable for employer and union groups enrolled in individual-market plans, when used (that is, when indicated in the "General Information" section of Worksheet 1).
- For EGWPs, an explanation of the consistency between the pricing in the bid and the expected underwriting assumptions for all groups, in aggregate. This documentation includes, but is not limited to, a description of the underwriting methodology.
- The input sheet(s) for the pricing model used in the development of the bid.
- An explanation of and detailed support for how CY2012 bid audit findings and observations were corrected in the current bid for the same plan. To the extent that an issue applies to other plans in the same contract or parent organization, the documentation for the audited plan must describe how the bids for all plans are treated consistently regarding that issue.
- Support for reliance on information supplied by others that—
    - Identifies the source(s) of the information—for example, name, position, company, date;
    - Identifies the information relied upon;
    - States the extent of the reliance—for example, whether or not checks as to reasonableness have been applied; and
    - Indicates to which plan(s) the reliance information applies.

See the sample format at the end of Appendix B.

Upon Request by CMS Reviewers

It is not required that the items below be uploaded with the initial June bid submission, but they must be prepared at that time in order to be readily available for CMS reviewers upon request. If substantiation is requested by CMS reviewers, it must be provided within 48 hours. These materials will be reviewed at audit:

- Support for the allocation of enrollment between DE# and non-DE# beneficiaries including the basis for classifying dual-eligible enrollees as DE# (Worksheets 1 and 5).
- Support for the pricing of the non-covered services, including utilization and unit cost (Worksheet 2, lines l through r, column o). (Support at the benefit level is required in the initial June bid submission.)

- Detailed support for cost-sharing utilization assumptions and plan-level deductible (Worksheet 3).
- Support for allocation of allowed costs and cost sharing between Medicare-covered and A/B mandatory supplemental benefits (Worksheet 4).
- Support for when the formulas provided in the BPT for DE# plan cost sharing (Worksheet 4, Section IIB, column f) are overwritten at the discretion of the certifying actuary.
- Support for variation in the gain/loss margin that accounts for the difference in risks between products for EGWPs and DE-SNPs (Worksheet 4).
- Copies of related-party agreements for a Plan sponsor who has entered into a related-party agreement with an organization that is providing services to unrelated parties.
- Support for the calculation of the "Medicaid Cost Sharing" in column k, including cost sharing required by state or territory Medicaid programs in the plan's service area based on the eligibility rules for subsidized cost sharing for DE# beneficiaries (Worksheet 4).
- Detailed support for the MSP adjustment (Worksheet 5).
- Justification for significant differences between the assumptions of corresponding employer-only group and individual-market products (such as the relationship of the bid to the benchmark). See Appendix D for more information.
- A letter supporting any information upon which the certifying actuary relied, if applicable. This letter must be signed by the person (source) who provided the information.
- Communication between CMS reviewers and the Plan sponsor throughout the bid review process (that is, e-mail communication) that was not uploaded to HPMS during bid review.
- Detailed support for how certain findings from the Office of Financial Management (OFM) audit were addressed in the current bid.

Additional information not specified in this list may be requested by CMS reviewers, as needed, at any point during the bid desk review process.

MA CHECKLIST FOR REQUIRED SUPPORTING DOCUMENTATION

Initial June Bid Submission – Required for All Bids
Cover sheet
Product narrative
Credibility assumption
Adjustment to cost sharing for OOP maximum
Cost-sharing category mapping
Non-benefit expenses
Gain/loss margin
Projected risk scores

Initial June Bid Submission – Required for All Bids with Specified Assumptions
Base period experience and projections
Projection Factors
Preventive services incentive programs
Hospice claims costs for mandatory supplemental
Manual rate development
Non-DE# projected allowed costs
Mapping of PBP and BPT service categories
Zero cost benefit
Cost of benefit included in non-benefit expenses
Non-covered services benefit-level summary
Disclosure of related-party agreements
ESRD "subsidy"
Zero DE# member months
ISAR factors
Optional supplemental experience for 2011
OSB packages: benefit, non-benefit, and gain/loss margin
Actuarial swaps/equivalences
EGWP comparison of bid pricing and expected underwriting assumptions
Input sheets for pricing model
Bid audit results
Reliance information

Upon Request by CMS Reviewers
Enrollment allocation (DE#/non-DE#)
Non-covered services pricing details
Cost-sharing utilization and plan-level deductible
Allocation of allowed costs/cost sharing to Medicare-covered and non-covered
Override of formulas for DE# plan cost sharing
Variation in gain/loss margin (EGWPs/DE-SNPs)
Related-party agreements

State and territory cost sharing requirements
MSP adjustment
Differences in EGWP and general market pricing assumptions
Reliance letter
Bid review communications
OFM audit results
Other

SAMPLE COVER SHEET – SUBMITTED WITH INITIAL BID UPLOAD IN JUNE

Supporting Documentation Cover Sheet #1

CY2013 Bid Submission

Organization Name: Health One

Contract(s): H1234, H9999, and S9999

Date: June 5, 2012

Documentation Requirement	Specific Bid ID(s) or N/A	File Name	Location within File (if Applicable)	Applies to: MA, PD, or Both
Cover sheet	All bids	Cover Sheet 6-1-2012.pdf	Page 1	both
Product narrative	All bids	Cover Sheet 6-1-2012.pdf	Pages 2-4	both
Credibility assumption	All bids	Cover Sheet 6-1-2012.pdf	Page 5	both
Cost sharing mapping	All bids	Cover Sheet 6-1-2012.pdf	Page 6	both
Non-benefit expenses	All bids	AdminProfit.xls	Sheet 1	both
Gain/loss margins	All bids	AdminProfit.xls	Sheet 2	both
Risk scores	All bids	Risk CY2013.xls	MA-Sheet 1 PD-Sheet 2	both
Manual rates	H1234-003-0 S9999-001-0	Manual.xls	Section II	PD
ESRD subsidy	H1234-001-0 H1234-004-0	Manual.xls	Section I	MA

SAMPLE COVER SHEET – SUBMITTED AS A SUBSEQUENT SUBSTANTIATION UPLOAD

Supporting Documentation Cover Sheet #2

CY2013 Bid Submission

Organization Name: Health One

Contract(s): H1234, H9999, and S9999

Date: July 16, 2012

Documentation Requirement	Specific Bid ID(s) or N/A	File Name	Location within File (if Applicable)	Applies to: MA, PD, or Both
Cover sheet	H1234-001-0 H1234-003-0 H1234-004-0 H1234-801-0 H9999-001-0 S9999-001-0	Cover Sheet 7-16-2012.doc	n/a	both
E-mail communication with CMS bid reviewers	H1234-001-0 H1234-003-0 H1234-004-0 H9999-001-0	Email1.doc	n/a	MA
E-mail communication with CMS bid reviewers	H9999-001-0 S9999-001-0	Email2.doc	n/a	PD
E-mail communication with CMS bid reviewers	H9999-001-0 S9999-001-0	Email3.doc	n/a	PD

SAMPLE FORMAT FOR RELIANCE ON INFORMATION SUPPLIED BY OTHERS

Bid ID	MA or PD or Both	Source (Name, Position, Company)	Type of Information	Comments
H1234-002-00	MA and PD	Joe Smith, Director of Finance, ABC Health Plan	Administrative expenses, gain/loss margin	
H1234-002-00	MA and PD	Jane Doe, Medicare Analyst, ABC Health Plan	Claim modeling, risk score	I have not performed any independent audit or otherwise verified the accuracy of these data or information.

SAMPLE FORMAT FOR THE PROJECTED RISK SCORE DEVELOPMENT SUMMARY

Organization Name: Health One

Contract(s): H1234

Date: June 5, 2012

Projected risk scores were calculated under the CMS preferred methodology for all plans in H1234 except H1234-004-00. CY2012 MMR data were used to determine the starting risk score for H1234-004-00 due to inordinate shifts in enrollment during 2011. See the "H1234 Risk Score" file for the development of the projected risk scores.

Step	Description	H1234-001-00
A	Starting risk score	1.0500
B	Covert to raw – remove normalization (multiply)	n/a
C	Covert to raw – remove MA coding pattern adj (divide)	n/a
D	Transition from lagged to non-lagged diagnosis data	n/a
E	Incomplete reporting of diagnosis data	n/a
F	Seasonality	n/a
G	Risk model adjustment	n/a
H	Missing diagnosis adjustment	n/a
I	Plan-specific coding trend at 4.0% annually	1.0816
J	Population change (plan specific)	1.0010
K	MA coding pattern differences (1.00-3.41%)	0.9659
L	Normalization factor	1.0790
M	Frailty factor	n/a
N	Final risk score [(A * B / C * D * E * F * G * H * I * J * K) / L] + M	1.0177

A – The average starting risk score is based on the risk scores in the beneficiary-level files provided by CMS for bid development, excluding ESRD and hospice. See the MA RS tab in the "H1234 Risk Score" file.

B – The starting risk score is not normalized; therefore, it does not require conversion to a raw risk score.

C – The starting risk score does not include the MA coding intensity factor; therefore, this factor does not need to be removed from the starting risk score.

D – The starting risk score includes the mid-year sweep adjustment; therefore, it represents non-lagged data.

E – The starting risk score reflects nearly complete run-out; therefore, a completions factor is not necessary.

F – The starting risk score reflects full calendar-year data; therefore, an adjustment for seasonality is not necessary.

G – n/a

H – n/a

I – Based on efforts to improve coding as explained in the "Plan Coding" tab of the "H1234 Risk Score" file.

J – See the "Population" tab of the "H1234 Risk Score" file.

K – The CY2013 MA coding pattern difference factor is specified by CMS in the bid instructions.

L – Since the preferred risk score calculation approach is used, the FFS normalization factor is the unadjusted FFS normalization factor for CY2013 specified by CMS in the bid instructions.

M – n/a

N – The projected risk score (normalized).

APPENDIX C – PART B-ONLY ENROLLEES

This appendix includes bid requirements for plans that cover only enrollees eligible for Medicare Part B. An RPPO plan must cover enrollees eligible for both Medicare Part A and Part B.

Medicare beneficiaries with Medicare coverage only under Part B have not been allowed to elect an MA plan since December 31, 1998 unless they were members of employer or union groups.

However, Medicare beneficiaries (with Part B coverage under Medicare) who were Medicare enrollees of a Section 1876 contractor on December 31, 1998 were considered to be enrolled with that organization on January 1, 1999 if the organization had an MA contract for providing benefits on the latter date. Health benefit coverage that MA organizations provide to such remaining Part B-only enrollees constitutes a separate MA plan (which requires a separate bid submission).

CMS encourages MA organizations to submit as few plans as possible for their pre-1999 Part B-only members, rather than duplicating each of their A/B plans. In fact, an MA organization can submit one plan for all its pre-1999 Part B-only members under an MA contract if they are in the same type of plan. In addition, if the plan is offering the pre-1999 Part B-only members the same benefits at the same price as those offered to A/B members (that is, members eligible for both Part A and Part B of Medicare), the Plan sponsor is not required to submit a separate bid for the Part B-only members.

On the other hand, MA organizations that enroll Medicare beneficiaries with Part B-only coverage in an employer-only group plan must prepare a separate Part B-only bid. If a separate Part B-only plan is not created, the CMS managed care payment system will reject any enrollments submitted on behalf of individuals without Part A.

MA organizations are to prepare Part B-only bids in much the same way as those prepared for Part A/B members.

In completing the bids for Part B-only plans, MA organizations must give special consideration to allocating the portion of services that are considered to be Medicare-covered (Worksheet 4, Section II, columns i and j):

- The Medicare-covered proportion of inpatient services (line a) must equal zero (0) percent.
- While the majority of Medicare expenditures for skilled nursing facilities (SNFs) are covered under Part A (Hospital Insurance), in certain circumstances benefits are covered under Part B (Supplementary Medical Insurance). Guidance on these covered services can be found in Section 70 of Chapter 8 of the *Medicare Benefit Policy Manual* at http://www.cms.gov/manuals/iom . We estimate that for calendar year 2013, about 5 percent of Medicare expenditures for SNFs will be covered under Part B.
- Also, as is stated in Section 60.3 of Chapter 7 of the *Medicare Benefit Policy Manual*, if a beneficiary is enrolled only in Part B and is qualified for the Medicare home health benefit, then all of the home health services are financed under Part B. Thus, for most Part B-only plans, the Medicare-covered proportion of home health services (line c) will be 100 percent.

APPENDIX D – MEDICARE ADVANTAGE PRODUCTS AVAILABLE TO GROUPS

(EMPLOYER GROUPS AND UNION GROUPS)

Organizations have two options for offering Medicare Advantage (MA) products to members of employer and union groups: individual-market plans and employer-only or union-only group waiver plans (that is, EGWP or "800-series" plans).

Individual-Market Plans ("Mixed Enrollment" plans)

Essentially, MA organizations may either offer their individual-market products without modification or they may tailor the products to specific employer and union groups through two types of allowable customization: "actuarial swapping" or "actuarial equivalence."

Actuarial Swaps

If you are requesting the actuarial swapping category of customization, identify in the supporting documentation both the benefits that might be swapped during negotiations with employers and/or unions and the MA plan covering those benefits. Only supplemental benefits not covered under original Medicare are eligible for actuarial swapping, and only those benefits in your bids that are candidates for swaps need to be identified. When you make specific swaps in negotiations with employers or unions, you can do so in the context of the CMS general approval of your candidates, without obtaining further approval from CMS for the actual swaps.

Actuarial Equivalence

If you request the actuarial equivalence category of customization allowable for employer and union groups, provide the following information as supporting documentation:

- The cost-sharing amounts you intend to change and the MA plan containing the cost sharing.
- Any modification to the premium you will charge.
- Any improvement in the benefit related to the changed cost sharing.

Unlike the actuarial swapping flexibility, this customization can apply to both covered and non-covered Medicare benefits.

Please retain in your files a package of documents with computations supporting the proposed changes under these two types of allowable customization. Do not include those packages of documents in the backup material that you submit to CMS.

Employer-Only or Union-Only Group Waiver Plans (EGWPs)

The MMA gives employers and unions multiple options for providing Medicare coverage to their Medicare-eligible active employees and retirees. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), those options include making special

arrangements with MA organizations to purchase customized benefits for their active employees and retirees or contracting directly with CMS to sponsor a MA plan.

Under section 1857(i) of the Social Security Act (SSA), CMS may waive or modify requirements for the kinds of arrangements that "hinder the design of, the offering of, or the enrollment in" these employer or union-only sponsored group plans. CMS may exercise its statutory waiver authority for two basic types of MA plan entities: (i) MA organizations that offer or administer employer/union-only sponsored group waiver plans ("EGWPs" or "employer-only group plans"); and (ii) employers/unions that directly contract with CMS to themselves offer an employer/union-only sponsored group waiver plan ("Direct Contract" EGWPs).

See Chapter 9 of the *Medicare Managed Care Manual* (MMCM), which can be found at:

http://www.cms.gov/Manuals/IOM/itemdetail.asp? filterType=none&filterByDID=-99& sortByDID=1&sortOrder=ascending&itemID=CMS019326 .

As described in Chapter 9 of the MMCM, organizations may offer MA plans that are available only to employer and union groups. These plans must follow all MA bidding requirements, except those that are specifically waived per Chapter 9 of the MMCM.

Following are some of the key features to be reflected in employer-only group bids:

- Base period data must reflect actual experience for the groups enrolled.
- Total projected allowed costs for Medicare-covered services reflect the composite characteristics of the individuals expected to enroll in the plan for the contract year.
- The pricing in the bid must reflect the expected underwriting assumptions for all groups, in aggregate.
    - Each employer-only group bid must reflect the composite characteristics of the individuals expected to enroll in the plan for the contract year. These characteristics include, but are not limited to, the following: risk scores, geographical distribution of enrollees, non-benefit expenses, and gain/loss margins.
    - Projected enrollment within the plan's service area must be consistent with the location of employer groups.
- The cost sharing priced in Worksheet 3 must correspond to that contained in the PBP.
    - The PBP can be prepared using either the expected composite benefit plan or the Medicare fee-for-service benefit provisions.
    - If the PBP reflects Medicare fee-for-service benefits and an MA rebate is generated, then the user must enter the PMPM value of the medical costs associated with these additional "unspecified" benefits in Worksheet 4, Section IV.
- Generally, CMS expects that actuarial and financial assumptions supporting each employer-only group bid would bear a reasonable relationship to corresponding individual-market products offered by the organization. Significant differences between corresponding employer-only group and individual-market products (such as the relationship of the bid to the benchmark) must be based on actual credible experience. Organizations must provide documentation in support of differences in actuarial/ financial assumptions between the corresponding products.

- There is no requirement to charge the filed MA basic and supplemental premium to each employer or union group that enrolls in the plan. However, the average premium charged, weighted by enrollees, across all groups enrolled in the plan must correspond to (that is, be consistent with) the filed premium. This rule on premiums does not apply when the Medicare fee-for-service bidding approach is utilized, since these filed plans, and resulting premiums, are not an accurate depiction of what is actually being offered to employer/union groups.
- Following are the guidelines for rebates:
    - Similar to CMS' payment on behalf of beneficiaries enrolled in individual-market plans, a uniform rebate amount will be paid by CMS on behalf of each individual enrolled in an employer-only group plan.
    - The allocation of rebates may vary from employer to employer within the employer-only group plan. (The bid form contains one allocation.)
    - Employer-only group bids cannot reflect an allocation of rebates to the Part D basic premium or the Part D supplemental premium. However, plans may, in fact, allocate rebates to the Part D premium when negotiating with employer/ union groups.
    - Part B premium buydowns (that is, rebate allocation) must be the same for all enrollees within the same employer-only group plan.
    - Consistent with individual-market bids, rebates allocated to reduce members' Part B premium will be transferred to the Social Security Administration, not the MA organization.
    - All groups enrolled in an employer-only plan with supplemental A/B rebates (both reduction in A/B cost sharing and additional benefits) must receive supplemental benefits equal to the amount of the A/B rebate allocation. However, A/B supplemental benefits provided to each employer may be customized. Further, MA organizations may use the field in Worksheet 4, Section IV, line 1, "PMPM for additional/unspecified MS benefits," to account for A/B supplemental benefits that are likely to be customized.
    - All rebates must be accounted for and must be used only for the purposes provided for in law. Documentation that supports the use of all of the rebates on a detailed basis must be retained by the employer-only group plan.

For regional PPO EGWP plans, the initial June bid submission contains an estimated MA premium. The actual MA premium will not be known until August, when the regional benchmarks are calculated by CMS. Note that after the MA regional benchmarks are released by CMS, all regional MA Plan sponsors will be required to resubmit the MA BPTs in order to reflect the actual plan bid component (in Worksheet 5, cell M17). Regional MA plans may need to reallocate rebates accordingly. Note that this requirement also applies to EGWP regional MA plans (that is, all EGWP RPPOs will be required to resubmit the MA BPTs in August after the announcement of the regional MA benchmarks).

APPENDIX E – REBATE REALLOCATION AND PREMIUM ROUNDING

Organizations may resubmit bids in order to reallocate MA rebate dollars for certain plan bids after CMS publishes the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional benchmarks.

Rebate reallocation is required for some MA plans, is permitted (but not required) for others, and is not permitted for certain plans, as indicated in this appendix. The rebate reallocation guidance applies to plans with all types of pricing arrangements, including risk sharing and global capitation, and to pricing assumptions that were developed as a percent of revenue.

CMS will announce the exact dates of the rebate reallocation period when the Part D and MA benchmarks are released.

In addition to reallocation guidance, this appendix provides premium rounding rules and describes the premium rounding that is permissible during rebate reallocation.

I. REBATE REALLOCATION PERMISSIBILITY BY PLAN TYPE

MA-PD Plan sponsors may resubmit bids to reallocate rebates in order to return to the target Part D basic premium. Some MA-PD plans are required to reallocate rebates.

The target premium is communicated to CMS in the MA BPT in the initial June bid submission. The target may not be changed after initial submission.

MA-PD Plan sponsors have two options for the target premium. They can set it equal to—

- The basic Part D premium net of rebates (that is, the amount displayed in line 7d of Worksheet 6, Section IIIC), or
- The low-income premium subsidy amount.

This choice is designated on line 10 of Worksheet 6 Section IIIC; it is called the "Plan Intention for target Part D basic premium."

The target Part D basic premium concept does not apply to MA-only plans and EGWP plans, since these plans do not submit a Part D BPT.

All RPPO plans, including EGWPs, must resubmit during the rebate reallocation period, to reflect the published RPPO benchmarks within their bids.

The following tables summarize rebate reallocation permissibility during the rebate reallocation period for various plan types and rebate scenarios and show where examples can be found in this appendix. Additionally, the tables indicate if premium rounding is permitted during rebate reallocation.

MA-PD Plans with MA Rebate Dollars in the Initial June Bid Submission

Type of Plan	Rebate Scenario*	Rebate Reallocation	Premium Rounding	Example
Local (excluding EGWP)	Premium decreases below $0	Required	Permitted	1
Local (excluding EGWP)	Premium decreases but is greater than $0	Permitted	Permitted	2
Local (excluding EGWP)	Premium increases	Permitted	Permitted	3
RPPO		Required, to reflect the published MA regional benchmarks	Permitted	4

* Impact on the Part D basic premium net of rebates (line 7D of Worksheet 6, Section IIIC) of reflecting the CMS published benchmarks.

MA-PD Plans with No MA Rebate Dollars in the Initial June Bid Submission

Type of Plan	Rebate Reallocation	Premium Rounding
Local	Not applicable	Permitted (excluding EGWP)
RPPO	Required, to reflect the published MA regional benchmarks	Permitted

MA-Only Plans

Type of Plan	Rebate Reallocation	Premium Rounding
Local	Not permitted; these plans are not affected by the Part D and MA regional benchmarks	Not permitted; premiums must reflect desired rounding in the initial June bid submission
RPPO	Required, to reflect the published MA regional benchmarks	Permitted

II. REBATE REALLOCATION RULES AND EXAMPLES

A. Return to the Target Premium

When rebates are reallocated, the Part D basic premium net of rebate must be returned to the target premium indicated in the initial June bid submission. CMS will not accept a partial return to the target premium, except in the following situation: the Plan sponsor intends to return to the target premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the target premium.

B. Negative Part D Basic Premium Net of Rebate after Part D Benchmark Announcement

If, after reflecting announced Part D benchmarks, the Part D basic premium net of rebate is less than zero, rebate reallocation is required.

The amount of rebate allocated to buy down the Part D basic premium cannot exceed the amount of the pre-rebate premium. Therefore, if the premium resulting from application of the national average monthly bid amount and the base beneficiary premium is negative, then the "excess" rebate allocated to buy down the Part D basic premium must be reallocated to buy

down the other premiums (the A/B mandatory supplemental premium, the Part D supplemental premium, and/or the Part B premium).

Example 1.

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Resubmission
7a. Part D basic premium prior to rebates (rounded)	$36	$34	$34
7c. MA rebates allocated to Part D basic premium (rounded)	$36	$36	$34
7d. Part D basic premium	$0	-$2	$0
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable

The required change is the shift from a $36 to a $34 rebate allocation to the Part D basic premium in order to return to the target premium of $0. The "excess" $2 is allocated to buy down other premiums.

C. Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Less than Target Part D Basic Premium, but Not Less than Zero

Rebate reallocation to reduce the other premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental) is optional if the Part D basic premium net of rebate is lower than the target Part D basic premium, but not less than zero. The MA organization has the following two options for rebate allocation:

- Leave the final Part D basic premium net of rebate unchanged (that is, at the level resulting from application of the national average monthly bid amount and the base beneficiary premium), or
- Reallocate rebate in order to return to the target Part D basic premium. The rebate may be reallocated to reduce other beneficiary premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental).

Note: If the MA organization elects to allocate the "excess" rebate dollars to the other premiums, then the final Part D basic premium must equal the target premium. In other words, a partial return to the target premium will not be accepted.

Example 2.

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Option 1	Rebate Reallocation Option 2
7a. Part D basic premium prior to rebates (rounded)	$35	$30	$30	$30
7c. MA rebates allocated to Part D basic premium (rounded)	$15	$15	$15	$10
7d. Part D basic premium	$20	$15	$15	$20
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

The MA organization has one of the following two options for rebate allocation:

- No rebate reallocation; leave the Part D basic premium at the post-Part D benchmark announcement basic premium of $15. Resubmission is not necessary.
- Reallocate $5 of rebates to other premiums in order to return to the target Part D basic premium of $20.

Note: If the MA organization does not want to leave the post-Part D benchmark announcement premium at $15, only a return to $20 is acceptable, not a partial return of, for example, $18.

D. Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Greater than Target Part D Basic Premium

Rebate reallocation from other premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental) to the Part D basic premium in order to meet the target Part D basic premium is optional if the Part D basic beneficiary premium net of rebate is higher than the target premium (that is, the plan has insufficient rebates). The MA organization has the following two options for rebate allocation:

- Leave the final Part D basic premium net of rebate unchanged (that is, at the level resulting from application of the national average monthly bid amount and the base beneficiary premium), or
- Reallocate rebate that had been applied to the reduction of other premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental) toward the Part D basic premium, in order to return to the target D basic premium. If the MA organization does elect to reallocate additional rebate dollars from other benefits, the final Part D basic premium must be the target premium except in the following situation: the Plan sponsor intends to return to the target premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the target premium.

Example 3.

MA BPT Worksheet 6, Section IIIC, Line —	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Option 1	Rebate Reallocation Option 2
7a. Part D basic premium prior to rebates (rounded)	$35	$40	$40	$40
7c. MA rebates allocated to Part D basic premium (rounded)	$15	$15	$15	$20
7d. Part D basic premium	$20	$25	$25	$20
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

The MA organization has one of the following two options for rebate allocation:

- No rebate reallocation; leave the Part D basic premium at the post-Part D benchmark announcement Part D basic premium of $25. Resubmission is not necessary.
- Reallocate $5 of rebates from other premiums in order to return to the target Part D basic premium of $20.

Note: If the MA organization does not want to leave the post-Part D benchmark announcement premium at $25, only a return to $20 is acceptable, not a partial return , of, for example, $23, unless $23 is the result of allocating all rebates to the Part D basic premium.

E. Increase or Decrease in RPPO Total Rebate Dollars

Once CMS announces the MA regional benchmarks, there may be an increase or decrease in the total rebate dollars in a regional plan's bid. The allocation of rebate dollars must be revised to reflect the new total rebate dollars.

Example 4.

MA BPT Worksheet 6	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Option 1	Rebate Reallocation Option 2
Total MA rebate (IIIB, line 1)	$55	$53	$53	$53
MA rebates allocated to benefits other than Part D basic premium (IIIB, lines 2-4 and 6)	$40	$40	$38	$43
MA rebates allocated to Part D basic premium (rounded) (IIIB, line 5)	$15	$15	$15	$10
Total rebates allocated (IIIB, line 7)	$55	$55	$53	$53
Unallocated rebates	$0	-$2	$0	$0
Part D basic premium prior to rebates (rounded) (IIIC, line 7a)	$35	$30	$30	$30
Part D basic premium net of rebates (IIIC, line 7d)	$20	$15	$15	$20
Plan intention for target Part D basic premium (IIIC, line 10)	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

The MA organization has one of the following two options for rebate allocation:

- Leave the basic Part D premium net of rebate at the post-Part D benchmark announcement premium of $15. Subtract $2 of rebates that were allocated to other premiums such that the total rebates allocated equal the total rebates available.
- Reduce the rebate allocation for the basic Part D premium by $5 in order to return to the target Part D basic premium of $20. Reallocate $3 of rebates to other premiums in order to return to the target Part D basic premium of $20.

F. Every Plan Bid Must Allocate the Exact Amount of the Plan's Total Rebate

The exact amount of the plan's total rebate must be allocated among the various options described above. MA organizations must account for all rebate dollars in a plan's bid. Moreover, the amount of rebate allocated to each benefit (A/B mandatory supplemental, Part B, Part D) must not exceed the value of that benefit. For example, if the Part D supplemental premium is $50, an MA organization may not allocate more than $50 to buy down that premium. Rebate allocations to the Part B premium cannot exceed the estimated amount provided by CMS that is pre-populated in the bid pricing tool.

G. Examples in which Target Part D Basic Premium Is the Low-Income Premium Subsidy Amount (LIPSA) (and the Plan Desires to Return to the Target)

Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Less than LIPSA

If the Part D basic premium net of rebate is lower than the LIPSA, and LIPSA is designated as the target Part D basic premium, then the MA organization may increase the Part D basic premium in order to reach the target LIPSA by either (i) reallocating rebates to reduce other beneficiary premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental), or (ii) adding A/B mandatory supplemental benefits, in accordance with this appendix, and reallocating rebates to reduce the premium for the newly added benefits.

Note: The final Part D basic premium must equal the target premium unless all of the rebates are allocated to the Part D basic premium and it is still less than the LIPSA.

Example 5a.

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation
7a. Part D basic premium prior to rebates (rounded)	$35	$30	$30
7c. MA rebates allocated to Part D basic premium (rounded)	$15	$15	$12
7d. Part D basic premium	$20	$15	$18
10. Plan intention for target Part D basic premium	LIPSA	Not applicable	Not applicable
LIPSA	Not applicable	$18	$18

The LIPSA is less than expected, and the Part D basic premium post-benchmark is less than the LIPSA. To return to the target LIPSA, the only option that the MA organization has is to reallocate rebates to other benefits/premiums.

Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Greater than LIPSA

If the Part D basic premium net of rebate post-benchmark is greater than the LIPSA, then the MA organization may lower the Part D basic premium to the target LIPSA by reallocating the rebate to the Part D basic premium that was applied to buy down other premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental). If the MA organization chooses to reallocate additional rebate dollars from other premiums, the final Part D basic premium must equal the LIPSA except in the following situation: the Plan sponsor intends to return to the target premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the LIPSA.

Example 5b. (Similar to Example 3)

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation
7a. Part D basic premium prior to rebates (rounded)	$35	$40	$40
7c. MA rebates allocated to Part D basic premium (rounded)	$15	$15	$25
7d. Part D basic premium	$20	$25	$15
10. Plan intention for target Part D basic premium	LIPSA	Not applicable	Not applicable
LIPSA	Not applicable	$15	$15

The LIPSA is less than expected, and the Part D basic premium post-benchmark is greater than the LIPSA. To return to the target LIPSA, the only option the MA organization has is to reallocate rebates from other benefits/premiums to the Part D basic premium.

H. First-Time Allocation of Rebate Dollars to Part D Basic Premium during the Rebate Reallocation Period.

In the June bid submission, an MA-PD plan with MA rebate dollars may have opted not to allocate any of the rebate to buying down the Part D basic premium. For these bids, if the Part D basic premium after application of the Part D national average monthly bid amount and the base beneficiary premium were to be higher than the target premium, CMS would allow a return to the plan's target premium.

Example 6.

MA BPT Worksheet 6, Section IIIC, Line —	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Option 1	Rebate Reallocation Option 2
7a. Part D basic premium prior to rebates (rounded)	$10	$15	$15	$15
7c. MA rebates allocated to Part D basic premium (rounded)	$0	$0	$0	$5
7d. Part D basic premium	$10	$15	$15	$10
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

III. ADDITIONAL REBATE REALLOCATION GUIDANCE

Changes Allowed to Funding of the Part D Basic and Supplemental Benefits

During the rebate reallocation period, rebate dollars that are not used to reach the target premium for basic Part D coverage may be used to buy down the Part D supplemental premium. However, no modifications are allowed to the benefit design or pricing of the Part D

basic benefit or the supplemental benefit offered under the "enhanced alternative" design. That is, this prohibition includes that no changes are permitted to the allowed costs, administrative costs, or gain/loss margin in the Part D basic and supplemental benefits.

Changes Allowed to Funding of the A/B Mandatory Supplemental Benefits

The A/B mandatory supplemental benefit includes reductions in cost sharing for Part A/B items and services from levels actuarially equivalent to average cost sharing under original Medicare and additional items and services not covered by original Medicare. CMS will not allow MA organizations to substantially redesign A/B mandatory supplemental benefits during the rebate reallocation period. CMS expects only marginal adjustments during this period and will evaluate material differences.

The value of the added or eliminated A/B mandatory supplemental benefit is required to match the amount of rebate that must be shifted to return to the Part D target premium. For a regional plan, the value of added benefits is required to match the net shift in total MA rebate dollars due to an increase or decrease in those dollars after application of the regional benchmark and/or return to the Part D target premium. CMS will not allow the MA organization to eliminate one additional benefit and then add another additional benefit.

When the Part D basic premium net of rebate is lower than the target Part D basic premium after the Part D benchmark announcement, the MA organization could—

- Further buy down the initial A/B mandatory supplemental premium;
- Reduce plan cost sharing and then buy down the new A/B mandatory supplemental premium to the initial level; or
- Add new non-drug benefits (for example, vision) to the A/B mandatory supplemental benefit package and then buy down the new A/B mandatory supplemental premium to the initial level.

Example 7.

After application of the national average monthly bid amount and the base beneficiary premium, an MA-PD organization's Part D basic premium net of rebates shifts from $0 to -$3. The MA organization is required to reallocate $3 of rebates and may decide to buy down the cost of a benefit in the A/B mandatory supplemental package.

However, CMS will not allow the MA organization to accomplish rebate reallocation by changing the value of benefits by more than $3, for example, by moving $15 out of A/B cost-sharing reductions and moving $18 into an additional benefit. We would consider this to be a substantial redesign of the A/B mandatory supplemental benefit.

When the Part D basic premium net of rebate is greater than the target Part D basic premium after the Part D benchmark announcement, the MA organization could—

- Buy down less of the A/B mandatory supplemental premium; or
- Eliminate or reduce an A/B mandatory supplemental benefit (for example, provide an eye exam less frequently), and then buy down the new A/B mandatory supplemental premium to the initial level.

Similarly, to return a regional plan with a decrease in the total amount of rebate to the original premium, the MA organization could, for example, eliminate from the A/B mandatory supplemental benefit package the coverage of a non-Medicare covered item or service.

The CY2010 Call Letter included the following guidance regarding benefit changes during rebate reallocation (page 22):

> ***"III. Bidding***
>
> **Rebate Re-allocation**
>
> . . .
>
> In situations when MA-PD plans are allowed to re-allocate Part C rebate dollars in order to return to the Target Part D basic premium (due to "insufficient allocation" resulting in a Part D basic premium larger than the target premium or due to a reduction in the total amount of rebate for a regional plan), MAOs should make re-allocations that reflect the following priorities. Specifically, there may not be any reduction of rebate allocated to priority (3) unless reductions have first been made to priority (1), then priority (2) noted below.
>
> 1. Reduce or remove non-Medicare covered benefits;
> 2. Increase cost sharing for widely-used services such as primary care visits; and
> 3. As a last resort**,** increase cost sharing for more limited-use services such as inpatient, skilled nursing facility (SNF), and home health care.
>
> MAOs that do not adhere to this guidance may be asked to resubmit."

Changes Allowed to the Part B Premium Reduction

One use of rebate dollars allowed under 42 CFR §422.266 is reduction of the Part B premium. During the rebate reallocation period, rebate dollars allocated for this purpose may be increased or decreased. However, the maximum amount of rebate that can be allocated to reduce the Part B premium is equal to the amount of the estimated Part B premium released by CMS in the BPT.

Plans Required to Include Prescription Drug Coverage

MA organizations must meet the 42 CFR §423.104(f) requirement on type of drug coverage offered by certain plans and must reallocate the rebate, if necessary, to meet this requirement.

In accordance with 42 CFR §423.104(f), MA organizations may not offer an MA coordinated care plan in an area unless that plan (or another MA plan offered by the same MA organization in the same service area) includes required prescription drug coverage.

Required prescription drug coverage is defined by 42 CFR §423.100 as MA-PD plan coverage of Part D drugs that is either—

- Basic prescription drug coverage (that is, defined standard coverage, actuarially equivalent standard coverage, or basic alternative coverage); or
- Enhanced alternative coverage with no beneficiary premium for the Part D supplemental benefit. An MA-PD plan must apply rebate dollars to reduce to zero the beneficiary premium for the Part D supplemental benefit.

MA organizations are required to comply with this rule. If necessary, MA organizations must reallocate rebate dollars from other benefits to achieve the required Part D supplemental benefit in the plan.

To restate: MA organizations offering coordinated care plans must offer in an area either (i) a basic-only Part D plan or (ii) a basic plus supplemental Part D plan for which the supplemental premium (net of rebates) equals zero. Failure to meet this requirement will result in the organization's inability to offer a Part D benefit. In addition, MA organizations that offer coordinated care plans but that fail to offer a Part D benefit in an area will be unable to offer an MA benefit as well, under the rules of 42 C.F.R. §422.4(c).

Non-Benefit Expenses and Gain/Loss Margins

This guidance applies to all pricing arrangements and methodologies, including percent of revenue, risk sharing, and global capitation.

Changes to A/B Mandatory Supplemental

CMS will allow only the following minor changes to non-benefit expenses and the gain/loss margin as a result of rebate reallocation:

- A change, if any, in non-benefit expenses related to the incremental change of A/B mandatory supplemental benefits.
- A small change in the gain/loss margin related to premium rounding (see premium rounding rules in Appendix E).
- A small change resulting from the proportional allocation of non-benefit expenses and the gain/loss margin in the BPT.

Changes to Medicare-Covered

CMS will allow only the minor modifications specified below to the pricing of Medicare-covered benefits as a result of rebate reallocation; that is, the PMPM value of allowed costs, non-benefit expenses, and the gain/loss margin may not change except for—

- A small change, if any, in allowed costs directly related to a change in utilization due to the change in A/B mandatory supplemental benefits.
- A small change in non-benefit expenses and the gain/loss margin resulting solely from the proportional allocation of non-benefit expenses and the gain/loss margin in the BPT.

Local MA Plan Segments

The above rules on rebate reallocation apply to bids for local MA plan segments, with the following clarifications.

Segmentation does not apply to the Part D benefit. The Part D prescription drug benefit must be uniform across a plan's service area; it may not vary across segments. Therefore, prior to the allocation of rebates to buy down the premium, the Part D basic and supplemental premium must be the same across segments. However, the amount of rebates allocated to buy down Part D basic and supplemental premiums may differ by segment.

IV. RULES FOR ROUNDING PREMIUMS

This section describes system requirements for rounded premiums and the circumstances in which the Plan sponsor may round premiums in order to reach plan premium goals.

Rule 1 – System Requirements Regarding Premiums and Rebates

To comply with premium withhold system requirements, the BPTs round the following premiums to the nearest one decimal: MA (the sum of basic plus mandatory supplemental), Part D basic, and Part D supplemental. No pennies are allowed.

Rebate dollars allocated to reduce the Part B and Part D premiums are rounded to one decimal.

Rebate dollars allocated to reduce the A/B mandatory supplemental premium are rounded to two decimal places.

Note: Prescription Drug Plans (PDPs) express their intention to round the Part D premium in the initial June bid submission, because the rebate reallocation period does not apply to PDPs. In the Part D bid pricing tool, PDPs are permitted to round their premiums to either the nearest $0.10 or the nearest $0.50.

Rule 2 – Local MA-Only Plans

For local MA-only plan bids, the plan premium submitted in the initial June bid submission is considered the final premium, as these bids are not affected by the Part D national average calculation or the MA regional plan benchmark calculations. Local MA-only plans will not be given an opportunity to round the premiums after the initial June bid submission. If a local MA-only Plan sponsor wishes to offer a "whole-dollar" premium, the initial June bid submission must reflect a total premium that is rounded to the nearest dollar. The bid assumptions (such as gain/loss margin) must support the desired plan premium and the desired level of premium rounding.

Rule 3 – Local MA-PD Plans (excluding EGWPs) and RPPOs

Regional plans and local MA-PD plans (excluding local EGWPs) may participate in the rebate reallocation process. During rebate reallocation, MA organizations may round the total plan premium to the nearest dollar (up or down) by slightly increasing or reducing the gain/loss margin in the MA bid, as long as the change in margin results in a total plan premium change of less than $0.50. (The total plan premium is defined at 42 CFR §422.262(b) as the consolidated monthly premium consisting of the combination of the MA basic and mandatory supplemental premiums and the Part D basic and supplemental premiums.)

If the plan has rebate dollars, then the MA organization may make a small change in the gain/loss margin to result in an increase or decrease in rebate dollars of no more than $0.50. Note that, in order to account for the proportional allocation of the total gain/loss margin to

Medicare-covered and A/B mandatory supplemental in the BPT, and also to account for the savings retained by Medicare, the total margin may change by slightly more than $0.50. Specifically, the Medicare-covered margin (Worksheet 4, cell Q105) would be limited to:

- At the 73⅓% rebate level: limited to a $0.68 Medicare-covered margin change, to result in a $0.50 change in rebates ($0.68 × 73⅓% = $0.50).
- At the 71⅔% rebate level: limited to a $0.70 Medicare-covered margin change, to result in a $0.50 change in rebates ($0.70 × 71⅔% = $0.50).
- At the 66⅔% rebate level: limited to a $0.75 Medicare-covered margin change, to result in a $0.50 change in rebates ($0.75 × 66⅔% = $0.50).

If the plan A/B bid is equal to or greater than the A/B benchmark, the MA organization may make a small change in the gain/loss margin resulting in a premium increase or decrease of up to $0.50.

Examples of rounding.

Example (a). An MA-PD plan has no premium for Medicare-covered or A/B mandatory supplemental benefits, and an initial basic Part D premium (target premium) of $30. (This situation could occur if (i) the bid equals the benchmark, and no A/B mandatory supplemental benefits are offered, or (ii) the bid is less than the benchmark, and the plan has A/B mandatory supplemental benefits and applies rebates to reduce the A/B mandatory supplemental premium to zero.) If the post-Part D benchmark announcement total plan premium is $30.42, the MA organization could round the plan premium to $30.00 by generating $0.42 of additional rebates to allocate to the basic Part D premium by slightly reducing the gain/loss margin for MA benefits. (The gain/loss margin for Part D benefits must not change.)

Example (b1). An MA-PD plan has no premium for Medicare-covered or A/B mandatory supplemental benefits, and an initial basic Part D premium (target premium) of $30. (This situation could occur if (i) the bid equals the benchmark, and no A/B supplemental benefits are offered, or (ii) the plan applies rebates to reduce the A/B mandatory supplemental premium to zero.) If the post-Part D benchmark announcement bid results in a total plan premium of $32.42, the MA organization could opt to generate $0.42 of additional rebates to allocate to the basic Part D premium by making a slight reduction in the gain/loss margin for MA benefits that would result in a premium of $32.00.

The MA organization could not use the rounding rules to adjust the premium to anything lower than $32. For example, the organization could not round to a combined premium of $30 by reducing the gain/loss margin to result in a premium change of $2.42. To return to the premium of $30, the MA organization would have to engage in rebate reallocation. See earlier sections of this appendix for guidance on rebate reallocation.

Example (b2). An MA-PD plan has A/B mandatory supplemental benefits, an initial basic Part D premium (target premium) of $30, and a total plan premium of $70.00. If the post-Part D benchmark announcement bid results in a basic Part D premium of $28.55 and a total plan premium of $68.55, the MA organization could opt to make a

slight change in the gain/loss margin for MA benefits in order to achieve a $0.45 increase in premium for A/B mandatory supplemental benefits, resulting in a total plan premium of $69.00.

The MA organization could not use the rounding rules to adjust the premium to anything higher than $69. For example, the organization could not round to a combined premium of $70 by increasing the gain/loss margin to result in a premium change of $1.45. To return to the target premium of $30, the MA organization would have to engage in rebate reallocation. See earlier sections of this appendix for guidance on rebate reallocation.

Example (c). An MA-PD plan has no rebates and an initial total plan premium of $25. The post-Part D benchmark announcement total plan premium is $26.52. The MA organization could round the plan premium to the nearest dollar (that is, $27.00) by increasing the gain/loss margin to generate a $0.48 MA premium.

Example (d). The target Part D basic premium is the low-income premium subsidy amount. After the Part D national average monthly bid amount is calculated, the Part D basic premium is $32.00, and the low-income premium subsidy amount is $31.60. The plan has the following three options:

> ***Option 1.*** The plan can maintain its Part D basic premium of $32.00. The plan's beneficiaries eligible for the full subsidy will pay a Part D basic premium of $0.40.
>
> ***Option 2.*** The MA-PD plan can reallocate $.40 of the rebates that were allocated to the A/B mandatory supplemental premium to its Part D basic premium, thus reducing the premium to the low-income premium subsidy amount of $31.60. To account for the reduction in rebates applied to the A/B mandatory supplemental premium, the MA-PD plan may either increase its A/B mandatory supplemental premium by $0.40 or reduce its gain/loss margin appropriately to eliminate the premium increase. Enrollees not eligible for the low-income subsidy would pay a Part D basic premium of $31.60.
>
> ***Option 3.*** In order to be able to offer a rounded Part D basic premium to enrollees not eligible for the low-income subsidy, MA-PD plans are permitted in this situation to reallocate A/B mandatory supplemental rebates to reduce their Part D basic premium to the nearest whole-dollar amount below the regional low-income premium subsidy amount. Therefore, the MA-PD plan can reallocate $1.00 of its A/B mandatory supplemental rebates to its Part D basic premium, reducing the Part D basic premium to $31.00, which is the nearest whole-dollar amount below the regional low-income premium subsidy of $31.60. To account for the reduction in A/B mandatory supplemental rebates applied to MA, the MA-PD plan must increase its A/B mandatory supplemental premium by $1.00 and cannot offset the reduction by a change in the gain/loss margin. Please note that in this option, the MA-PD plan forgoes $0.60 in potential low-income premium subsidy dollars per each beneficiary eligible for the full subsidy.

Example (e). The target Part D basic premium is the LIPSA. After the Part D national average monthly bid amount is calculated, the low-income premium subsidy amount is $31.76. Since Part D premiums must be rounded to one decimal, it is acceptable for the plan to round the Part D basic premium to $31.70 or to $31.80, as follows:

Option 1. If the plan were to round the Part D basic premium to $31.70, then it would receive $31.70 as the 100-percent subsidy. The plan's beneficiaries eligible for the full subsidy would not pay a Part D basic premium, since the premium is lower than the LIPSA.

Option 2. If the plan were to round the Part D basic premium to $31.80, then it would receive $31.80 as the 100-percent subsidy. In this case, the plan's beneficiaries eligible for the full subsidy would not pay a Part D basic premium, since the $0.04 difference (that is, $31.80 less $31.76) rounds to zero when the premiums are rounded to one decimal.

Example (f). An MA-PD plan has three segments, with MA premiums of $51, $76, and $110. The Part D basic premium after the benchmark announcement is $37.90. To ultimately achieve whole-dollar total plan premiums, the MA organization could increase the MA gain/loss margin requirements to increase each MA premium by $0.10. When added to the $37.90 Part D premium, the total plan premium for each segment becomes a whole-dollar amount: $89, $114, and $148.

Example (g). The initial June bid submission for a local MA-only plan includes a $0 basic MA premium and a $61.30 mandatory supplemental MA premium. The Plan sponsor would like to offer a whole-dollar premium to the plan's enrollees. Before submitting the initial BPT to CMS (via HPMS upload), the actuary would slightly revise the gain/loss margin to accomplish the rounded premium. For example, the actuary could reduce the gain/loss margin by $0.30 to achieve the $61.00 rounded premium. This adjustment must be completed before the BPT is submitted to CMS in early June. Note that Plan sponsors are not allowed to make significant changes to the BPT in order to round premiums. Local MA-only plans do not participate in rebate reallocation.

V. SUMMARY OF CONSIDERATIONS FOR REBATE REALLOCATION RESUBMISSIONS

When preparing resubmissions during the rebate reallocation period, plans should review the following considerations:

- All RPPOs (including EGWPs) must resubmit during the rebate reallocation period, in order to reflect the published regional MA benchmarks.
- If the national average monthly bid amount (NAMBA) and base beneficiary premium (BBP) result in a Part D basic premium that is lower than the rebates allocated to Part D basic, then the bid must be resubmitted.
- When resubmitting bids during the rebate reallocation period, plans must update the NAMBA and BBP in the Part D BPT.
- The Part D bid must be unchanged.
- The Part D basic premium net of rebates must equal the target.

- If the LIPSA is targeted, the resubmitted Part D basic premium net of rebates must be equal to the plan's LIPSA (rounded to the nearest dime or rounded down to the nearest dollar).
- The "plan's intention for the target premium" in the MA BPT must be unchanged.
- Changes to MA pricing assumptions (benefit/non-benefit /gain/loss) must be consistent with these instructions.

APPENDIX F – SUGGESTED MAPPING OF MA PBP CATEGORIES TO BPT CATEGORIES

The Medicare Advantage (MA) Bid Pricing Tool (BPT) contains benefit categories that do not correlate line-by-line with the MA Plan Benefit Package (PBP). The BPT was developed to include a reasonable number of benefit categories for pricing purposes and to provide benefit groupings that are consistent with organizations' accounting and claims systems.

The chart below provides a suggested mapping of the PBP and BPT benefit categories. This mapping is not intended to represent the only method of reporting benefits in the BPT; rather, it contains one suggested method that may be used. Other reasonable mappings may also be used at the actuary's discretion. The cost sharing reported on Worksheet 3 must clearly identify which PBP benefit service categories are priced in each of the BPT service categories (see Worksheet 3 instructions for more details).

HPMS contains a "Medicare Benefit Description Report" with further information regarding the PBP service categories and a list of PBP/SB software changes dated January 31, 2012. In addition, the *Medicare Managed Care Manual* may be a helpful resource regarding benefit design.

PBP line #	**PBP Service Category**	**BPT line #**	**Corresponding BPT Service Category: Description/Note (Worksheet 3)**
1a	Inpatient Hospital - Acute	a1	Inpatient Facility: Acute
1b	Inpatient Psychiatric Hospital	a2	Inpatient Facility: Mental Health
2	Skilled Nursing Facility	b	Skilled Nursing Facility
3	Cardiac and Pulmonary Rehabilitation Services	h5	Outpatient Facility - Other: Other
4a	Emergency Care	f	Outpatient Facility - Emergency
4b	Urgently Needed Services	f	Outpatient Facility - Emergency
5	Partial Hospitalization	h3 h5	OP Facility - Other: Mental Health; or OP Facility - Other: Other
6	Home Health Services	c	Home Health
7a	Primary Care Physician Services	i1	Professional: PCP
7b	Chiropractic Services	i2 i6	Professional: Specialist excl. MH; or Professional: Other
7c	Occupational Therapy Services	i4	Professional: Therapy (PT/OT/ST)
7d	Physician Specialist Services Excluding Psychiatric Services (exclude Radiology)	i2 i6	Professional: Specialist excl. MH; or Professional: Other
7d	Physician Specialist Services Excluding Psychiatric (Radiology only)	i5	Professional: Radiology
7e	Mental Health Specialty Services	i3	Professional: Mental Health
7f	Podiatry Services	i2 i6	Professional: Specialist excl. MH; or Professional: Other
7g	Other Health Care Professional Services	i2 i6	Professional: Specialist excl. MH; or Professional: Other
7h	Psychiatric Services	i3	Professional: Mental Health

PBP line #	PBP Service Category	BPT line #	Corresponding BPT Service Category: Description/Note (Worksheet 3)
7i	Physical Therapy/Speech Therapy Services	i4	Professional: Therapy (PT/OT/ST)
8a	OP Diagnostic Procedures/Tests/Lab Services	h1	OP Facility - Other: Lab
8b	OP Diagnostic/Therapeutic Radiological Services	h2	OP Facility - Other: Radiology
9a	Outpatient Hospital Services	g or h	OP Facility - Surgery; or OP - Facility - Other (all sub-categories)
9b	Ambulatory Surgical Center (ASC) Services	g	OP Facility - Surgery
9c	Outpatient Substance Abuse	h5	OP Facility - Other: Other
9d	Outpatient Blood Services	h5 or k	OP Facility - Other: Other or Other Medicare Part B
10a	Ambulance	d	Ambulance
10b	Transportation	l	Transportation (Non-Covered)
11a	Durable Medical Equipment (DME)	e1	DME/Prosthetics/Supplies: DME
11b	Prosthetics/Medical Supplies	e2	DME/Prosthetics/Supplies: Prosthetics/Supplies
11c	Diabetes Supplies and Services	e2	DME/Prosthetics/Supplies: Prosthetics/Supplies
12	End-Stage Renal Disease	h4	OP Facility - Other: Renal Dialysis
13a	Acupuncture	q	Other Non-Covered
13b	Over-the-counter Rx	q	Other Non-Covered
13c	Meal Benefit	q	Other Non-Covered
13d	Other 1	q	Other Non-Covered
13e	Other 2	q	Other Non-Covered
14a	Medicare-covered Zero Cost-Sharing Preventive Services	k, i1, i2 or i6	Other Medicare Part B; Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14b	Supplemental Preventive Health Benefits	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14c	Supplemental Education/Wellness Programs	p	Health & Education (Non-Covered)
14d	Kidney Disease Education Services	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14e	Diabetes Self-Management Training	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
15	Medicare Part B Rx Drugs	j	Part B Rx
16a	Preventive Dental	m	Dental (Non-Covered)
16b	Comprehensive Dental	m	Dental (Non-Covered)
17a	Eye Exams	n1	Vision (Non-Covered): Professional
17b	Eye Wear	n2	Vision (Non-Covered): Hardware
18a	Hearing Exams	o1	Hearing (Non-Covered): Professional
18b	Hearing Aids	o2	Hearing (Non-Covered): Hardware

APPENDIX G – DE# SUMMARY

Medicaid Eligibility Data

The Medicaid status codes in the beneficiary-level file provided by CMS indicate the Medicaid eligibility status of the beneficiary as reported by the respective state Medicaid agency. These codes are shown in the table below. For descriptions of the dual-eligible beneficiary categories, and of the types of Medicaid benefits to which these beneficiaries are entitled, see http://www.cms.gov/DualEligible .

Medicaid Status Code	Medicaid State-Reported Code (Dual-Eligible Category)
01	QMB only
02	QMB + full Medicaid benefits
03	SLMB only
04	SLMB + full Medicaid benefits
05	QDWI (Qualified Disabled and Working Individual)
06	QI (Qualified Individual)
08	Full-benefit dual-eligible beneficiaries who do not have QMB or SLMB status
09	Other dual-eligible beneficiaries without full Medicaid benefits—for example, those in Pharmacy Plus and 1115 drug-only demonstrations
99	Unknown, including Medicaid-eligible beneficiaries reported by plans and territories
Blank	Non-Medicaid

Classifying Dual-Eligible Data

The HPMS plan-level data also include a Medicaid grouping indicator as shown in the table below. This table illustrates how the data for dual-eligible beneficiaries are classified as DE# or non-DE#. The certifying actuary must consider the Medicaid cost-sharing policy for the states or territories in the plan's service area when determining which beneficiaries in Medicaid grouping B are in the DE# population.

Medicaid Grouping	Dual Eligible	Category of Dual Eligible	Medicaid Status Code	Medicare Cost-Sharing Liability	DE# Status
A	Dual	QMB and QMB+	01, 02	None	DE#
B	Dual	Other Medicaid	03, 04, 05, 06, 08, 09, 99	Reduced (as determined by the certifying actuary)	DE#
B	Dual	Other Medicaid	03, 04, 05, 06, 08, 09, 99	Full (as determined by the certifying actuary)	Non-DE#
C	Non-dual	Non-Medicaid	Blank	Full	Non-DE#

The following table outlines the requirements for classifying dual-eligible beneficiaries that are not QMB or QMB+ (that is, Medicaid Indicator B: Other Medicaid) as DE# or non-DE#. The percentages in the table below represent the number of total dual-eligible beneficiaries relative to total members per the HPMS plan-level data.

Medicaid Grouping/Status Code	Condition	DE# Determination for Base Period Data
A: 01, 02	None	DE#
B: 03, 04, 05, 06, 08, 09, 99	<10% total dual-eligible beneficiaries	May consider as non-DE# or determine actual classification
B: 03, 04, 05, 06, 08, 09, 99	10% to 100% total dual-eligible beneficiaries	Must determine actual classification
C: Blank	None	Non-DE#

BPT Values

The following table outlines the determination of certain BPT values when the certifying actuary chooses to set the projected DE#, non-DE#, and total allowed costs all equal on Worksheet 2.

BPT Area	Input Item	<10% DE#	>90% DE#	10% to 90% DE#
WS3	Utilization and PMPM values	Enter non-DE# or total values	Enter non-DE# or total values[1]	N/A
WS4 IIB	State Medicaid required beneficiary cost sharing (column k)	Enter zero or appropriate values[2]	Enter appropriate values[3]	N/A
WS5 II	Non-DE# risk factor	Enter total values	Enter total values	N/A

[1] Enter total values if DE# projected member months equal total projected member months.

[2] Plus plan cost sharing for non-covered, non-Medicaid benefits.

[3] Plus plan cost sharing for non-covered, non-Medicaid benefits.

The next table summarizes the determination of certain BPT values when (1) the value for the DE# projected member months is less than 10 percent, or greater than 90 percent, of the total projected member months and the certifying actuary chooses to separately calculate DE# and non-DE# projected allowed costs; or (2) the value for the DE# projected member months is between 10 percent and 90 percent inclusive of the total projected member months.

BPT Area	Input Item	Determination of BPT Values
WS3	Utilization and PMPM values	Enter non-DE# values
WS4 IIB	State Medicaid required beneficiary cost sharing (column k)	Determine appropriate values (including zero)[4]
WS5 II	Non-DE# risk factor	Determine distinct non-DE# and DE# values

The table below outlines the determination of BPT values in which the requirements are the same for all bids regardless of the percentage of DE# members.

BPT Area	Input Item	Determination of BPT Values
WS3	Cost-sharing values and description	Reflect PBP package
WS4 IIB	Plan cost sharing (column f)	Default to non-DE# ratio of plan cost sharing or override formulas
WS4 V	DE# Medicaid data	Determine appropriate values
WS5 II	Non-DE# member months	Determine distinct non-DE# and DE# values

[4] Plus plan cost sharing for non-covered, non-Medicaid benefits.

APPENDIX H – MEDICAL SAVINGS ACCOUNT BPT

This appendix provides guidance in completing the Medical Savings Account Bid Pricing Tool for Medical Savings Account (MSA) plans offered to Medicare beneficiaries. This appendix highlights only the differences between the MSA BPT and the MA BPT.

The MSA bid form is organized as outlined below:

Worksheet 1 – MSA Base Period Experience and Projection Assumptions
Worksheet 2 – MSA Total Projected Allowed Costs PMPM
Worksheet 3 – MSA Benchmark PMPM
Worksheet 4 – Enrollee Deposit and Plan Payment PMPM
Worksheet 5 – Optional Supplemental Benefits

WORKSHEET 1 – MSA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS (CORRESPONDING TO MA WORKSHEET 1)

SECTION I – GENERAL INFORMATION

Line 7 – Plan Type

Enter MSA.

Line 8 – Deductible Amount

Enter the deductible amount that each beneficiary will pay for Medicare-covered benefits. The maximum deductible for CY2013 for MSA plans is $10,600.

Line 9 – Enrollee Type

This cell is pre-populated with "A/B".

SECTIONS II, III, IV, AND V

Base period data in Sections II, III, IV, and V must include only Medicare-covered medical expenses.

WORKSHEET 2 – MSA TOTAL PROJECTED ALLOWED COSTS PMPM (CORRESPONDING TO MA WORKSHEET 2)

SECTION II – PROJECTED ALLOWED COSTS

Data in Section II must include only Medicare-covered medical expenses.

WORKSHEET 3 – MSA BENCHMARK PMPM (CORRESPONDING TO MA WORKSHEET 5)

Follow the instructions for MA Worksheets 5 and 6 for the appropriate inputs.

WORKSHEET 4 – ENROLLEE DEPOSIT AND PLAN PAYMENT (NO CORRESPONDING MA WORKSHEET)

This worksheet calculates the MSA monthly plan revenue requirement and enrollee deposit.

Consistent with other MSA worksheets, information provided on Worksheet 4 must exclude ESRD enrollees.

SECTION II – DEVELOPMENT OF CLAIM INFORMATION INTERVALS (PLAN'S RISK FACTOR AND EXCLUDE SERVICES COVERED WITHIN THE DEDUCTIBLE)

Column c – Annual Projected Claim Interval

The column is pre-populated with annual projected claim intervals.

Column d – Annual Average Claim Amount

Enter the annual average claim amount paid in each claim interval.

Column e – Percentage of Member Months (Use Only the Highest Claim Interval)

Allocate the total projected member months to the highest claim interval expected by percentage.

For example, if 20 percent of the member months are expected to incur annual claims of $11,500, and 10 percent are expected to incur annual claims of $4,400, then put 20 percent only in the interval containing $11,500 and 10 percent only in the interval containing $4,400. The sum of column e must equal 100 percent.

Column f – Gross Claims (PMPM)

This column calculates total allowed Medicare-covered claims on a PMPM basis for each claim interval. No entry is required. The sum of column f must equal the total Medicare-covered medical expenses shown in column o of Worksheet 2.

Column g – Gross Claims over Deductible (PMPM)

Enter the total allowed Medicare-covered claims on a PMPM basis over the deductible for each claim interval expected to be paid by the MSA plan. Enter zero (0) for claim intervals below the deductible.

SECTION III – DEVELOPMENT OF SUMMARY INFORMATION (PLAN'S RISK FACTOR)

Line a – Medicare-Covered Plan Medical Expenses PMPM

This cell displays the sum of column g of Section II.

Line b – Non-Benefit Expenses

Enter the non-benefit expense information. Please refer to the "Pricing Considerations" section of these instructions for further guidance.

Do not leave a field blank to indicate a zero amount. If zero is the intended value, enter a 0 in the cell.

Line c – Gain/Loss Margin

Input the projected PMPM for the gain/loss margin for Medicare-covered services provided. Please refer to the "Pricing Considerations" section of these instructions for further guidance.

Do not leave a field blank to indicate a zero amount. If zero is the intended value, enter a 0 in the cell.

Line d – Total Plan Revenue Requirement

This cell is calculated automatically as the sum of projected Medicare-covered medical expense, non-benefit expense, and gain/loss margin.

Line e – Projected Plan Benchmark

This cell displays the value from Section III, column h, line 1 of Worksheet 3—the weighted average for the service area of the risk-adjusted ratebook values.

Line f – Projected Monthly Enrollee Deposit

This cell calculates the monthly enrollee deposit by subtracting the total plan revenue requirement from the projected plan benchmark.

Line g – Percent of Plan Revenue Ratios

These cells calculate the ratio of medical expense, non-benefit expense, and gain/loss margin as a percentage of revenue.

Line h – Standardized Plan Benchmark

This cell displays the value from Section III, column g, line 1 of Worksheet 3—the weighted average for the service area of the unadjusted ratebook values.

WORKSHEET 5 – OPTIONAL SUPPLEMENTAL BENEFITS (CORRESPONDING TO MA WORKSHEET 7)

Follow the instructions for MA Worksheet 7 for the appropriate inputs.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0944. The time required to complete this information collection is estimated to average 30 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.